

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ZDM 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET 04660									
CERTIFICATE OF DEATH					04660				
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ferndale</b> c. LENGTH OF STAY IN 1b <b>25 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1514 Church Lane</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ferndale</b> d. STREET ADDRESS <b>1514 Church Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>LOUIS</b>		First		Middle		Last		4. DATE OF DEATH Month <b>4</b> Day <b>18</b> Year <b>1966</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/2/1805</b>		9. AGE (In years last birthday) <b>80</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>		11. BIRTHPLACE (County & State, or foreign country) <b>San Francisco, Calif.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <b>212-12-5912</b>		17. INFORMANT <b>James E. Fowler Jr.</b> Address <b>1514 Church Lane</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , 19 <b>Apr. 18</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5 Mar. 1966</b> , and that death occurred at <b>10 A.M.</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Joseph Taler</b>						22b. DATE SIGNED <b>4/18/1966</b>		22c. PHYSICIAN'S NAME (Type) <b>JOSEPH TALER</b>	
22d. ADDRESS <b>95 Hephernst Rd. Glen Burnie, Md.</b>						22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/20/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Glen Burnie, Md.</b>		23e. REC'D BY REGISTRAR <b>APR 20 1966</b>	
24. FUNERAL DIRECTOR <b>Raymond C. Fink</b>						24b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



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VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RIVA</b> c. LENGTH OF STAY IN 1b <b>Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>RIVA, ROAD</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RIVA</b> d. STREET ADDRESS <b>RIVA ROAD</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>ARDELIA</b> Last <b>ALSQUITH</b>					4. DATE OF DEATH Month <b>APRIL</b> Day <b>13</b> Year <b>1966</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cau.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 1, 1874</b>		9. AGE (In years last birthday) <b>91</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Prince George Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANK P. BURGESS</b>					14. MOTHER'S MAIDEN NAME <b>SOPHIA KIRBY</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-38-3008</b>		17. INFORMANT <b>EDWARD ALSQUITH /</b> Address <b>RIVA ROAD, RIVA, MD.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221 Gen. arteriosclerotic cardio-vascular disease</b> DUE TO (b) <b>disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>40</b> , to <b>Apr. 13, 1966</b> , that (II) (we) last saw the deceased alive on <b>April 12, 1966</b> , and that death occurred at <b>7:20 AM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>S. Borssuck, M.D.</b>					22b. DATE SIGNED <b>4/16/66</b>		22c. PHYSICIAN'S NAME (Type) <b>S. Borssuck, M.D.</b>		
22d. ADDRESS <b>Amos Garrett Blvd., Annapolis, Md.</b>					22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/16/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DAVIDSONVILLE METH. CEM.</b>		23d. LOCATION (City, town or county) (State) <b>DAVIDSONVILLE A.A.CO. MD.</b>			
24. FUNERAL DIRECTOR <b>HOPPING FUNERAL HOME</b> ADDRESS <b>172 WEST ST. ANNAPOLIS, MD.</b>					25a. REC'D BY REGISTRAR <b>APR 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Huntingtown</i> 04-2						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>North Arundel Hospital</i>					d. STREET ADDRESS <i>04-2</i>						
3. NAME OF DECEASED (Type or print) First <i>Annie</i> Middle <i>Mary</i> Last <i>Aist</i>					4. DATE OF DEATH Month <i>April</i> Day <i>29</i> Year <i>1966</i>						
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 17, 1891</i>		9. AGE (In years last birthday) <i>75</i> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>same</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Delaware</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Peter Delange Robinson</i>					14. MOTHER'S MAIDEN NAME <i>Annie Delange</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>					16. SOCIAL SECURITY NO. <i>4200</i>		17. INFORMANT <i>George R. Aist Jr.</i> Address <i>Huntingtown Md.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Left Ventricular Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Centrodental Heart Disease &amp; Chronic Hypertension</i> (c) <i>Anger thyroidism</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Anger thyroidism</i>										INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i> <i>approx 5-6 hours</i>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>4-27</i> , 19 <i>66</i> , to <i>4-29</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>4-29</i> , 19 <i>66</i> , and that death occurred at <i>4:50</i> AM, from the causes and on the date stated above.											
22a. SIGNATURE <i>H. T. O'Heirly</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>4-29-66</i>				
22c. PHYSICIAN'S NAME (Type) <i>H. T. O'HEIRLY M.D.</i>					22d. ADDRESS <i>5 CENTRAL AVE, Glen Burnie</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>5-2-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cem.</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore Maryland</i>					
24. FUNERAL DIRECTOR <i>Willie Donaldson Laurel, Md.</i>					25a. REC'D BY REGISTRAR <i>MAY 5 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

1872

Nov 2 1888

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04663

## CERTIFICATE OF DEATH

04663

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Unknown Md.		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 40 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown/ Catonsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS Unknown 6 Jones Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #02292 Minnie		First Middle Last Anderson		4. DATE OF DEATH Month Day Year 4 7 19 66			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1898		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 442 x IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Hypertensive Arteriosclerotic Cardiovascular DUE TO Renal Disease (c) -----						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypostatic Pneumonia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/24, 1926, to 4/7/1966, that (I) (we) last saw the deceased alive on 4/7/1966, and that death occurred at 4:45 M, from causes on and on the date stated above.							
22a. SIGNATURE Charles J. Hays		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/7/66			
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Hays, M.D.		22d. ADDRESS Crownsville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-11-1966		23c. NAME OF CEMETERY OR CREMATORY Crownsville Memorial		23d. LOCATION (City or Town) (County) (State) Md.	
24. FUNERAL DIRECTOR William Rose II 108 W. Washington St. Annapolis		ADDRESS		25a. REC'D BY REGISTRAR APR 15 1966		25b. REGISTRAR'S SIGNATURE Charles J. Hays	

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## CERTIFICATE OF DEATH

04664

04664

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. LENGTH OF STAY IN lb <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Shady Side</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CARRIE Eileen</b>		First Middle Last <b>ARMOUR</b>		4. DATE OF DEATH Month <b>April</b> Day <b>18</b> Year <b>1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>May 4, 1893</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Henry Bell</b>				14. MOTHER'S MAIDEN NAME <b>IDA V. Sheiblein</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>WM ARMOUR, Shadyside, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarct</b> DUE TO (b) <b>Coronary artery disease</b> DUE TO (c) <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myxedema.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>March 5, 1966</b> , to <b>April 18, 1966</b> that (I) (we) last saw the deceased alive on <b>April 18, 1966</b> , and that death occurred at <b>6:20 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Gerard Blumer</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/18/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>GERARD H. BLUMER</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>April 21, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DRUID Ridge</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md</b>	
24. FUNERAL DIRECTOR <b>T A Hardisty 12 R. D. Gely Ave Annapolis, Md</b>				25a. REC'D BY REGISTRAR DATE <b>APR 22 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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1974

CERTIFICATE OF DEATH

1974

Age at death

Sex

Place of birth

2000

1 day

1 day

Time of death

Time of death

Time of death

Time of death

Time of death

Time of death

Time of death

Time of death

Time of death

John V. Zepherin

William Henry Bell

William Henry Bell

1974

1974

1974

1974

1974

John V. Zepherin

William Henry Bell

John V. Zepherin

William Henry Bell



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04665

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04665

1. PLACE OF DEATH a. COUNTY <u>ALCO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ALCO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCK</u>		c. LENGTH OF STAY IN lb <u>ROCK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DON - North. HUNDEL - Hosp.</u>		d. STREET ADDRESS <u>Center &amp; Kennedy Dr.</u>	
3. NAME OF DECEASED (Type or print) First <u>LORRAINE</u> Middle <u>Baby</u> Last <u>LOW</u>		4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 20, 1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE (In years last birthday) yrs. <u>54</u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Ludwig</u>		14. MOTHER'S MAIDEN NAME <u>Same as #2</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mr. Clair D. Babylon (Husband)</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular</u> 4344 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Shiller</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. H. H. H.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. H. H. H.</u>		22. DATE SIGNED <u>4-17-66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 21, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>
23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, MD.</u>			
24. FUNERAL DIRECTOR <u>R. V. Singleton</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>APR 21 1966</u>	

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1982-1983

FOR STATE HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04666

04666

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>A.A.CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND.</u> b. COUNTY <u>A.A.CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A - North. ARUNDEL - Hosp.</u>		d. STREET ADDRESS <u>22 M. Haley-Neck-Road.</u>	
3. NAME OF DECEASED (Type or print) First <u>Edward.</u> Middle <u>M.</u> Last <u>Ballman</u>		4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10, 1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Same Operator (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>United Iron &amp; Metal Co.</u>	9. AGE (In years last birthday) yrs. <u>63</u>
11. BIRTHPLACE (State or foreign country) <u>Brooklyn, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Ballman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Schultz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-07-7344</u>	
17. INFORMANT <u>Mrs. Ellen M. Ballman (wife)</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis C.V. Disease</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt.</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>4622166</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 25, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, A.A.Co., Md.</u>
24. FUNERAL DIRECTOR <u>R.V. Singleton</u>		25a. REC'D BY REGISTRAR <u>APR 26 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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ESTIMATE

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04667

## CERTIFICATE OF DEATH

04667

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>48 Market Place</b>	
3. NAME OF DECEASED (Type or print) <b>3-# Frank</b>		4. DATE OF DEATH Month <b>4</b> Day <b>23</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 18, 1921</b>
9. AGE (In years lost birthday) yrs. <b>44</b>		IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Wyoming</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Baskes</b>		14. MOTHER'S MAIDEN NAME <b>Sophie Baskes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>3221</b> IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> DUE TO (b) <b>Chronic Alcoholism</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Acute Brain Syndrome Secondary to Alcoholic Intoxication</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. --- 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4/21</b> , 19 <b>66</b> to <b>4/23</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4/23</b> , 19 <b>66</b> , and that death occurred at <b>5:30 A.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>L. Benedict</i>		22b. DATE SIGNED <b>4/27/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>5/3/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Univ. of Maryland</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Wm. R. Rouse</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 5 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04668 CERTIFICATE OF DEATH 04668									
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> c. LENGTH OF STAY IN 1b <b>Glen Burnie</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> d. STREET ADDRESS <b>7839 Americana Circle Apt 102</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>G.</b> Last <b>BAUER *SR.</b>			4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>1966</b>						
5. SEX <b>Male</b>	6. CDLDR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>18 March 1904</b>	9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months <b>02</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>10</b> Min. <b>21</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Representative</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Pide-Piper</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Charles Bauer</b>					14. MOTHER'S MAIDEN NAME <b>Susa Sauer</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>214-01-7015</b>		17. INFORMANT <b>Lillian L. Bauer - Same as #2</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-vascular Disease</b> <b>4281</b> DUE TO (b) <b>Arterio-sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH <b>1-3 hr</b> <b>5-6 hr</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1946</b> , to <b>4/30</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4/30</b> , 19 <b>66</b> , and that death occurred at <b>10 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Charles L. Ball Jr.</b>					22b. DATE SIGNED <b>4/30/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>Charles L. Ball</b>					22d. ADDRESS <b>203 W. Maple Road, Linthicum, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>5/3/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Pk.</b>		23d. LOCATION (City, town or county) (State) <b>Glen Burnie, Maryland</b>		
24. FUNERAL DIRECTOR <b>A. V. Singleton</b>					25a. REC'D BY REGISTRAR <b>MAY 3 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
Singleton Funeral Home/ Glen Burnie, Md.									

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04669

04669

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Benfield Rd.,</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> d. STREET ADDRESS <u>Benfield</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>William</u> Middle <u>Montgomery</u> Last <u>Beall</u>				<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>26</u> Year <u>1966</u>					
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>January 6, 1879</u>			
<b>9. AGE</b> (In years last birthday) <u>87</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>ret- well digger</u>			
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Well Drilling</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Anne Arundel Co., Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Thomas O. Beall</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Hammond</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>218-12-9012</u>		<b>17. INFORMANT</b> <u>Box 104 Mr. George Beall-son Crownsville, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Flu</u> (a), stating the underlying cause last. (c) <u>Ca of months</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 days</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Aug 51</u> <b>1962</b> <b>to</b> <u>April 26</u> <b>1966</b> , <b>that (I) (we) last saw the deceased alive on</b> <u>April 26</u> <b>1966</b> , <b>and that death occurred at</b> <u>9:20 PM</u> , <b>from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <u>Robert Dabolins</u> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>4-28-66</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>ROBERT DABOLINS, M.D.</u>				<b>22d. ADDRESS</b> <u>400 Gains Hwy N.W Glen Burnie, Md.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Apr. 30, 1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Baldwin Mem. Cemetery</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>Millersville, Md.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Beverly C. Hopping</u>				<b>25a. REC'D BY REGISTRAR</b> <u>APR 29 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

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STATE OF TEXAS

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04670

## CERTIFICATE OF DEATH

04670

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN lb <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>55 Amos Garrett Boulevard</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frances Stehle BEAN</u>				4. DATE OF DEATH Month Day Year <u>April 30 1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 27, 1906</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ANNAPOLIS MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES J. STEHLE</u>				14. MOTHER'S MAIDEN NAME <u>ALICE SPRIGGS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. CLIZABETH BEANS 117 SPALDING AVE</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of the liver</u> <u>5810</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>April 30</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>April 29</u> , 19 <u>66</u> , and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <u>John L. Hedeman</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <u>5:30 AM</u> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/30/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John L. Hedeman, M.D.</u>				22d. ADDRESS <u>1407 Forest Drive, Annapolis, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-2-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS MD</u>	
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR SONS</u>				ADDRESS <u>ANNAPOLIS MD</u>		25a. REC'D BY REGISTRAR <u>MAY 3 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04671

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04671

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>H. A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAPE ST. CHAIRE</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>RT #4</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CHARLES J. BENDA</u>				4. DATE OF DEATH <u>4 30 1966</u>		5. SEX <u>M</u>	
6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-27-1924</u>		9. AGE (In years last birthday) <u>41</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TOOL MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETO.</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOSEPH BENDA</u>				14. MOTHER'S MAIDEN NAME <u>HILDA NEUMAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>WW II</u>				16. SOCIAL SECURITY NO. <u>217-14-7433</u>		17. INFORMANT <u>MARGARET L. BENDA</u> #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4344</u> DUE TO <u>Cerebral Vascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Stroke</u> (c) <u>Subarachnoid</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <u>[Signature]</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <u>E. Linhorst</u> Address (Street, city, town, or county) <u>4/30/66</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-4-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE MD.</u>	
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR SONS ANNAPOLIS MD.</u>				25a. REC'D BY REGISTRAR <u>MAY 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18, and file it with the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1971

UNITED STATES DEPARTMENT OF STATE

1971

Mr. J. Edgar Hoover

Director

Washington, D.C.

Dear Mr. Hoover:

I am writing to you regarding the matter of the

recent visit of the Chinese delegation to the

United States and the subsequent press conference.

The information received from the Chinese side

indicates that the delegation was well received

and that the press conference was held in a

friendly atmosphere. The Chinese side expressed

its appreciation for the hospitality of the

United States and its interest in the

development of Sino-American relations.

I am sure that the information received from the

Chinese side is in line with the official

statement of the State Department.

04672

CERTIFICATE OF DEATH

04672

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY in 1b <b>1 month</b>		d. STREET ADDRESS <b>Port Street 724,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>#31597 Edward Bennett</b>		4. DATE OF DEATH Month <b>4</b> Day <b>3</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/25/06</b>
9. AGE (In years and birthday) yrs. <b>60</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cab Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Bennett</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>7/4/42 9/20/43</b>		16. SOCIAL SECURITY NO. <b>216-01-0438</b>	
17. INFORMANT <b>Mr. Lawrence Taylor</b>		Address <b>Hospital Records 724 N. Port St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Generalized Arteriosclerosis</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/21/66</b> , to <b>4/3/66</b> , that (I) (we) last saw the deceased alive on <b>4/3/66</b> , and that death occurred at <b>5:05 P.</b> M, from causes not on the date stated above.			
22a. SIGNATURE <b>L. Benedict, M.D.</b>		22b. DATE SIGNED <b>4/4/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M.D.</b>		22d. ADDRESS <b>Crownsville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/8/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Maryland</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>
24. FUNERAL DIRECTOR <b>HENRY SANDER &amp; SONS INC. Baltimore Md.</b>		25a. REC'D BY REGISTRAR <b>APR 11 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in a vault, within 72 hours after death.

57000

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APR 1 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04673 CERTIFICATE OF DEATH 04673									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn Maryland 22-1</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>					d. STREET ADDRESS <u>Bells Trailer Park</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>OLIE</u> Last <u>Bestland</u>					4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1966</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-25-75</u>		9. AGE (in years last birthday) <u>90</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARNIVAL OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AMUSEMENT</u>		11. BIRTHPLACE (County & State, or foreign country) <u>GRANITE FALLS MINN.</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>UNKNOWN</u>					14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>255-22-9310</u>		17. INFORMANT <u>HARRY L. BESTLAND -</u>			Address <u>Box 26 KERRIALA</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 491X DUE TO (b) <u>Pt. pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Brucella melitensis</u>									INTERVAL BETWEEN ONSET AND DEATH <u>12 day</u> <u>12 day</u> <u>12 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>4/12</u> , 19 <u>66</u> , to <u>4/12</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/12</u> , 19 <u>66</u> , and that death occurred at <u>5:00 A</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>W. H. Fink</u>								22b. DATE SIGNED <u>4/12/66</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>Glen Burnie, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/15/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>			23d. LOCATION (City, town or county) (State) <u>Glen Burnie, Md.</u>		
24. FUNERAL DIRECTOR <u>Raymond C. Fink</u>				25a. REC'D BY REGISTRAR <u>APR 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1123

Belis (Kaiser Park)

which was the first time  
that the children had been  
to the park.

The children were very  
happy and enjoyed the  
trip very much.

APR 15 1955  
Glen Burnie, Md.  
Glen Burnie, Md.  
Glen Burnie, Md.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 1-21 File 377 6-10-66		MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
04674		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
04674		04674	
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CROWNSVILLE STATE HOSPITAL		d. STREET ADDRESS 311 CHEDDINGTON ROAD	
3. NAME OF DECEASED (Type or print) First Middle Last ANNA A. BOCK		4. DATE OF DEATH Month Day Year April 19 19 66	
SEX Female		6. COLOR OR RACE White	
7. MARRIED X NEVER MARRIED WIDOWED DIVORCED		B. DATE OF BIRTH OCTOBER 21, 1932	
9. AGE (In years lost birthday) yrs. 33		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TELEPHONE CO. MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH KLEIN		14. MOTHER'S MAIDEN NAME OLGA REISLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-30-0774	
17. INFORMANT MR. GEORGE S. BOCK, JR.		Address 311 CHEDDINGTON RD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 780.2 IMMEDIATE CAUSE (a) Respiratory failure and cardiac arrest DUE TO during a convulsive seizure of unknown etiology Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES X NO	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 4-19-66	
ACTUAL SIGNATURE Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-22-66	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR HUBBARD FUNERAL HOME, 4107 WILKENS AVE. 21229		25a. REC'D BY REGISTRAR APR 22 1966	
25b. REGISTRAR'S SIGNATURE f Charles Judge			

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TECHNICAL REPORT

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FOR STATE HEALTH DEPT.

04675

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04675

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ADCO</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>ADCO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ODEUNTON</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kinbrough Army Hospital</b>		d. STREET ADDRESS <b>444 Telegraph Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Becky</b> Middle <b>mae</b> Last <b>Bauman</b>		4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 21 - 1938</b>
9. AGE (In years last birthday) <b>28</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telephone operator</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Margantown, W. Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James R. Bauman</b>		14. MOTHER'S MAIDEN NAME <b>Theodacia Metz</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>William Bauman, Margantown W. Va.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Injuries</b> DUE TO <b>8254</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>	
20a. EXTERNAL CAUSE WAS PRIMARY ( ) CONTRIBUTING ( ) CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto accident R 175.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>4:24</b> <b>19 66</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Road 175</b>		20f. (City or town) (County) (State) <b>ADCO MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>E. L. W. [Signature]</b> M.D.		22. DATE SIGNED <b>4/24/66</b>	
EXAMINER'S NAME (Type) <b>E. L. W. [Signature]</b>		23a. REC'D BY REGISTRAR <b>APR 29 1966</b>	
23b. DATE THEREOF <b>4-27-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St George Cem.</b>	
23d. LOCATION (City or Town) (County) (State) <b>Tucker Co W. Virginia</b>		23e. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
24. FUNERAL DIRECTOR <b>Delbert Donaldson</b>		ADDRESS <b>Laurel Md</b>	

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**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <u>A. A.</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN b. <u>02-1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>A. A. General</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A. A.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>98 College Ct, Tenace</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <u>Marie Boyd</u> First Middle Last <b>4. DATE OF DEATH</b> <u>4-11-1966</u> Month Day Year					<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>Col.</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>9-27-1923</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> yrs.				
<b>9. AGE</b> (In years last birthday) <u>42</u> <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Md</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>					<b>13. FATHER'S NAME</b> <u>John Robinson</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Robinson</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>4221</u> <b>17. INFORMANT</b> <u>Emma Boyd</u> Address <u>98 College Ct, Tenace</u>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis C.V. Disease</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>None</u> (a), stating the underlying cause last. DUE TO (c) <u>None</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> <b>20c. TIME OF INJURY</b> Month, Day, Year <u>4-11-66</u> Hour a.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>None</u> <b>20f. (City or town)</b> (County) (State) <u>Annapolis Md</u>									
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
<b>ACTUAL SIGNATURE</b> <u>E. L. Inghart</u> <b>EXAMINER'S NAME (Type)</b> <u>E. L. Inghart</u>					<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> M.D. <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>4-11-66</u>				
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>4-16-66</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Pine Lawn</u> <b>22d. LOCATION (City, town, or county)</b> (State) <u>Annapolis Md</u>					<b>23. FUNERAL DIRECTOR</b> <u>William Reese #</u> <b>24a. REC'D BY REGISTRAR</b> <u>4-15-1966</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>				

MEDICAL CERTIFICATION





## CERTIFICATE OF DEATH

04677

04677

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Franklin</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>12 hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>34 4th St.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Anne Cooney BRENNAN</b>		4. DATE OF DEATH Month Day Year <b>April 10 1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 14, 1899</b>
9. AGE (In years lost birthday) yrs. <b>67 66</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>ANDREW B. COONEY</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH FERRELL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>MR. JOHN F. COONEY</b>		Address <b>1000 VERMONT AVE. WASH. D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>12 h</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 10, 1966</b> , to <b>April 10, 1966</b> , that (I) (we) saw the deceased alive on <b>April 10, 1966</b> , and that death occurred at <b>7:35 PM</b> M. from causes and on the date stated above.			
22a. SIGNATURE <b>F.M. SHIPLEY</b>		22b. DATE SIGNED <b>4-11-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>F.M. SHIPLEY</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4-14-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOSEPH CEM.</b>	23d. LOCATION (City or Town) (County) (State) <b>MALONE N.Y.</b>
24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR SONS ANNAPOLIS MD</b>		25a. REC'D BY REGISTRAR DATE <b>APR 13 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>04678</p> <p><b>MARYLAND STATE DEPARTMENT OF HEALTH</b></p> <p><b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b></p> <p><b>CERTIFICATE OF DEATH</b></p> </div> <div> <p>04678</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>AA -</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George's</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severn, Md.</u> <u>02-1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel Co</u>						d. STREET ADDRESS <u>Queens town Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Loretta</u> First <u>—</u> Middle <u>BROOKS</u> Last			4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1966</u>								
5. SEX <u>F</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-5-04</u>		9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Prince George Cty.</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME <u>Mary Jones</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Adelaide Epps - Severn Md</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4341</u> DUE TO <u>Compaction Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3/31</u> , 19 <u>66</u> , to <u>4/13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/12</u> , 19 <u>66</u> , and that death occurred at <u>1:30</u> P.M., from the causes and on the date stated above.											
22a. SIGNATURE <u>Wayne B. Tate</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Wayne B. Tate, M.D.</u>						22d. ADDRESS <u>108 Central Ave., N.W. (G.B.)</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
<u>Burial</u>		<u>4-16-66</u>		<u>mt Calvary</u>		<u>Brooklyn SA Co Md</u>					
24. FUNERAL DIRECTOR <u>Dwinnell B. Oden - Balto. Md</u>						25a. REC'D BY REGISTRAR DATE <u>APR 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

11-058

THE UNIVERSITY OF CHICAGO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04679  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>35 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>Box 534</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPHINE ALVERTA BROWN</b>		4. DATE OF DEATH Month Day Year <b>April 14 19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 8 -1899</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>A.A.Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert Brown</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Alton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-26-2005</b>	
17. INFIRMANT <b>Albert A. Brown-Arnold, Maryland A.A.Co.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute carbon monoxide poisoning</b> DUE TO (b) <b>7824</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1962</b> , 19____, to <b>4-15-66</b> , 19____, that (I) (we) last saw the deceased alive on <b>4-12-66</b> , 19____, and that death occurred at ____ M, from the causes and on the date stated above.			
22a. SIGNATURE <b>A.T. Allen</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>A.T. Allen</b>		22d. ADDRESS <b>Cathedral St. Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 17-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Pine Lawn</b>		23d. LOCATION (City, town or county) (State) <b>Bestgate Rd. Annapolis, Md.</b>	
24. FUNERAL DIRECTOR <b>C.E. Hicks 111 Annapolis, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 19 1966</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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State of New York

County of ...

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04680

## CERTIFICATE OF DEATH

04680

<b>1. PLACE OF DEATH</b> a. COUNTY <u>A.A. Co.</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ST. MARGARETS</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MARGARETS</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>SARAH</u> First <u>F.</u> Middle <u>BROWN</u> Last				<b>4. DATE OF DEATH</b> Month <u>4</u> Day <u>9</u> Year <u>1966</u>					
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>7-7-1890</u>		<b>9. AGE</b> (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOME</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>HOUSEWIFE</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>ANNAPOLIS, MD.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>LEVIN P. KELLY</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>JULIA O'HARA</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				<b>16. SOCIAL SECURITY NO.</b> <u>ROHARD A. BROWN #2</u>				<b>17. INFORMANT</b> Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic heart disease, 2 mitral insufficiency + aortic stenosis.</u> (b) <u>410 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (c)								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>10 yrs.</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour a.m. _____ p.m. _____ Month, Day, Year <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Sept 4/7</u> <b>1966</b> , <b>to</b> <u>April 12</u> <b>1966</b> , <b>that (I) (we) last saw the deceased alive on</b> <u>4/7</u> <b>1966</b> , <b>and that death occurred at</b> <u>12 PM</u> <b>from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <u>[Signature]</u>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b>		<b>22b. DATE SIGNED</b> <u>4/11/66</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>7-12-66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>CEDAR Bluff</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>ANNAPOLIS MD.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>JOHN M. TAYLOR &amp; SONS</u>				<b>ADDRESS</b> <u>ANNAPOLIS, MD.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>APR 13 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>	

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

A.A. Co.  
24 MAR 1962

MD  
St. Margaret's

A.A. Co.

F W  
JAGAH

Brown

7-7-1890

X F

9

9

9

Kevin P. Kelly  
Horsewife

Julia O'HARA  
Annapolis, MD.

U.S.A.

Richard A. Brown #2

Examination of heart, lungs, & intestines  
unremarkable + normal

Richard A. Brown

Barbara H-12-6  
John M. Taylor + Sons  
Annapolis, MD.

Cedar Bluff  
Annapolis

Annapolis

MD.

X

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04681											
04681											
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Anne Arundel</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CRANNSVILLE</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CRANNSVILLE STATE HOSPITAL</u>					d. STREET ADDRESS <u>222 BELEVER AV</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>BROWN</u> Last <u>BROWN</u>			4. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>1966</u>								
5. SEX <u>M</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>7/19/1915</u>		9. AGE (In years last birthday) <u>50</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE</u>			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>WILLIAM MOREHEAD</u>					14. MOTHER'S MAIDEN NAME <u>LOUISE GREEN</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493X DUE TO PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CENTRAL NERVOUS SYSTEM SYPHILLIS 026X</u>										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>4/13/66</u> , 19 <u>66</u> to <u>4/18/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/18/66</u> , 19 <u>66</u> , and that death occurred at <u>5108</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Hollis Seunarine, M.D.</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>4/18/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>HOLLIS SEUNARINE</u>					22d. ADDRESS <u>CRANNSVILLE STATE HOSPITAL</u>						
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-11-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>				
24. FUNERAL DIRECTOR <u>Charles A. Rice 661 W. Bane St.</u>					ADDRESS		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
					DATE		APR 12 1966				



04682

## CERTIFICATE OF DEATH

04682

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>10 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>286 West St.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Edward BROWN</b>		4. DATE OF DEATH Month Day Year <b>April 15 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 23, 1903</b>
9. AGE (In years last birthday) <b>62 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truckers Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Wesley Brown</b>		14. MOTHER'S MAIDEN NAME <b>Annie Simms</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-05-0701</b>	
17. INFORMANT <b>Ruby P. Brown-286 West St. Anna. Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute Cardiac failure</b> <b>7824</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 15, 1966</b> , to <b>April 15, 1966</b> , that (I) (we) last saw the deceased alive on <b>April 15, 1966</b> , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <b>A T ALLEN</b>		22b. DATE SIGNED <b>4-16-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>A T ALLEN</b>		22d. ADDRESS <b>6 L Bechtel St</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 20-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Pine Lawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Bestgate Rd. Annapolis, Md.</b>	
24. FUNERAL DIRECTOR <b>C.E. Hicks 111 Annapolis, Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 19 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



2224



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>AN Co</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bristol</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AN Co</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bristol</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Ernest Preston Catterton</u> First Middle Last 4. DATE OF DEATH <u>April 29</u> 19 <u>66</u> Month Day Year				5. SEX <u>Male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 23, 1902</u> 9. AGE (in years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u> 11. BIRTHPLACE (County & State, or foreign country) <u>A.A. Co, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Ernest Albert Catterton</u> 14. MOTHER'S MAIDEN NAME <u>Annie Elizabeth Stallings</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>218.36.3093</u> 17. INFORMANT <u>Carrie B. Catterton, Bristol</u> Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer</u> <u>157X</u> DUE TO <u>Carcinoma head of pancreas</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>46</u> , to <u>29 Apr</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>29 Apr</u> , 19 <u>66</u> , and that death occurred at <u>8:15</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>[Signature]</u> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u> 22d. ADDRESS 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>May 2, 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u> 23d. LOCATION (City, town or county) (State) <u>Lothian, Md</u>				24. FUNERAL DIRECTOR <u>T.S. Hardesty + Son, Galesville, Md</u> 25a. REC'D BY REGISTRAR <u>MAY 5 1966</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04684									
04684									
1. PLACE OF DEATH a. COUNTY <u>ANN. Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Glen Burnie</u>			c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>			d. STREET ADDRESS <u>203- Delmont Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>LILLIE</u> Middle <u>M.</u> Last <u>Clock</u>					4. DATE OF DEATH Month <u>4</u> Day <u>1</u> Year <u>1966</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-3-74</u>		9. AGE (In years last birthday) <u>91</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>George H. Tase</u>					14. MOTHER'S MAIDEN NAME <u>IDA P. GRIFF</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-54-9800</u>		17. INFORMANT <u>DORIS ITALIADA</u>			Address <u>SAME AS #2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>7824</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from <u>3/28</u> , 19 <u>66</u> to <u>4/1</u> , 19 <u>66</u> , that (1) (we) last saw the deceased alive on <u>4/1</u> , 19 <u>66</u> , and that death occurred at <u>8:30</u> PM, from the causes and on the date stated above.									
22a. SIGNATURE <u>Wayne B. Tate M.D.</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>4/1/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>WAYNE B. Tate M.D.</u>					22d. ADDRESS <u>108 Central Ave</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>April 5, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Severn Md.</u>		
24. FUNERAL DIRECTOR <u>R.V. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00124

00124



George H. Jones

APR 11 1952

Charles Judge





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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04686  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04685  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY AA		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY AA	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 1 WEEK	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Hospital		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie	
3. NAME OF DECEASED (Type or print) First Middle Last William E. Conrad		4. DATE OF DEATH Month Day Year 4 - 2 - 19 66	
5. SEX m	6. COLOR OR RACE w	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 - 2 - 03
9. AGE (In years last birthday) 63 yrs.		10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) T V Tech		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Sunbury, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jasper Conrad		14. MOTHER'S MAIDEN NAME Clara Heintzleman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Dortha R. Conrad, same as 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) Gastro-intestinal hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 12 hours weeks 1/2 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/26, 1966, to 4/2, 1966, that (I) (we) last saw the deceased alive on 4/2 1966, and that death occurred at 8:09 PM, from the causes and on the date stated above.			
22a. SIGNATURE Max C Frank MD		22b. DATE SIGNED 4/2/66	
22c. PHYSICIAN'S NAME (Type) MAX C FRANK MD		22d. ADDRESS 425 SE Ritchie Hwy-Glen Burnie	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6 Apr. 66	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial		23d. LOCATION (City, town or county) (State) Howard County, Md.	
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.		25a. REC'D BY REGISTRAR APR 6 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

04787

Shirley, R.  
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Shirley, R.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04687  
04686  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8 1st. Ave.</b>				d. STREET ADDRESS <b>8 1st. Ave.</b>					
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>T.</b> Last <b>Cooke</b>				4. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>1966</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 11, 1898</b>			
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>02</b> Days <b>-1</b>		IF UNDER 24 HRS. Hours <b>00</b> Min. <b>00</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Burner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Ship Yard</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Balto. Md.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>									
13. FATHER'S NAME <b>Clinton Cooke</b>				14. MOTHER'S MAIDEN NAME <b>Lucy Dunn</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b># 1</b>		17. INFORMANT Address <b>Mrs. Anna E. Cooke 8 1st. Ave. 25</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>2 yr. +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 1, 1964</b> , to <b>April 23, 1966</b> , that (I) (we) last saw the deceased alive on <b>4-22 1966</b> , and that death occurred at <b>4 A.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>A.C. Sollod</b>				22b. DATE SIGNED <b>4-25-66</b>					
22c. PHYSICIAN'S NAME (Type) <b>A.C. SOLL0D</b>				22d. ADDRESS <b>707 E. FORT AVE - 30</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4 26 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>			
23d. LOCATION (City, town or county) (State) <b>Brooklyn, A. A. Co. Md.</b>									
24. FUNERAL DIRECTOR <b>Mc Cully</b>				ADDRESS <b>130 E. Fort Ave</b>		25a. REC'D BY REGISTRAR <b>APR 26 1966</b>			
						25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04688

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04687

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLEN BURNIE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLEN BURNIE</b>			
c. LENGTH OF STAY IN 1b <b>2 YEARS</b>				d. STREET ADDRESS <b>APT. D</b> <b>7493 FURNACE BRANCH ROAD</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7493 FURNACE BRANCH ROAD</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MARIE</b>		First <b>M.</b>		Middle <b>Curran</b>		Last	
4. DATE OF DEATH <b>4</b>		Month <b>4</b>		Day <b>4</b>		Year <b>1966</b>	
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 16, 1894</b>	
9. AGE (In years last birthday) <b>71</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		11. BIRTHPLACE (State or foreign country) <b>ANNE ARUNDEL CO., MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANK P. CURRAN</b>				14. MOTHER'S MAIDEN NAME <b>BARBARA SMITH</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MISS MARY L. CURRAN (SISTER)</b>		Address <b>SAME AS #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>uterine sarcoma</b> <b>4500</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____							INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>
22a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
22c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>E. Linhart</b>				22. DATE SIGNED <b>4/4/66</b>			
EXAMINER'S NAME (Type) <b>E. Linhart</b>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 7, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLY CROSS CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>BROOKLYN, R.F.D. MD.</b>	
24. FUNERAL DIRECTOR <b>R.V. SINGLETON</b>				25a. RECEIVED BY REGISTRAR <b>APR 11 1966</b>			
ADDRESS <b>GLEN BURNIE, MD.</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
04689 CERTIFICATE OF DEATH 04688										
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>608 - First Street</b>					d. STREET ADDRESS <b>608 - First Street</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>WASHINGTON</b> Last <b>DAVIS</b>					4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>1966</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 12-1894</b>		9. AGE (In years last birthday) <b>72</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate - self Employed</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>A.A.Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Virgle Davis</b>					14. MOTHER'S MAIDEN NAME <b>Mary Peale</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>220-32-3141</b>		17. INFORMANT <b>Virginia D. Bryant-606 Second St. Anna. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>about 9 yrs.</b>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 1957</b> to <b>4-12 1966</b> , that (I) (we) last saw the deceased alive on <b>4-12 1966</b> , and that death occurred at <b>5:20 A.M.</b> from the causes and on the date stated above.										
22a. SIGNATURE <b>A.T. Allen</b>					22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type) <b>A.T. Allen</b>		
22d. ADDRESS <b>Cathedral St. Annapolis, Md.</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>April 16-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Annapolis - Neck</b>		23d. LOCATION (City, town or county) (State) <b>Annapolis, Maryland</b>			
24. FUNERAL DIRECTOR <b>C.E. Hicks</b>					ADDRESS <b>111 Annapolis, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 19 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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## CERTIFICATE OF DEATH

04689

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>24 Riverdale Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Esther</b>		4. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 28, 1925</b>
9. AGE (In years last birthday) yrs. <b>40</b>		IF UNDER 1 YEAR Months <b>10</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>ROBERTO DELGADO</b>		14. MOTHER'S MAIDEN NAME <b>CONCEPTION PARADIS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>DR GUSTAVE DELGADO # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>170X</b> IMMEDIATE CAUSE (a) <b>Melanotic carcinoma of breast</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ OUE TO (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (do not) attended the deceased from <b>October</b> , 19 <b>65</b> , to <b>April 10</b> , 19 <b>66</b> , that (I) (not) saw the deceased alive on <b>April 10</b> , 19 <b>66</b> , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <b>General Blumel</b>		22b. DATE SIGNED <b>3:05 AM 4/11/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Berman et al.</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4-12-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARY'S CEM.</b>	23d. LOCATION (City or Town) _____ (County) _____ (State) <b>MD.</b>
24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR SONS</b>		25a. DECEASED BY REGISTRAR <b>APR 13 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04691 CERTIFICATE OF DEATH 04690									
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linthicum</b> c. LENGTH OF STAY IN 1b <b>years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>#510 Shipley Road</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linthicum</b> d. STREET ADDRESS <b>#510 Shipley Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>JULIET C. DISNEY</b>			First Middle Last		4. DATE OF DEATH <b>April 17, 1966</b>		Month Day Year		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>May 6, 1895</b>		9. AGE (In years last birthday) <b>70</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk (ret.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dep't Store</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Anne Arundel Co., Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Fulton Kelly</b>				14. MOTHER'S MAIDEN NAME <b>Nettie Clark</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>212 28 6860</b>		17. INFORMANT <b>Mr. Robert Weldon Disney (son)</b> Address <b>Balto., Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> <b>4201</b> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>several years.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>April 2, 1966</b> , to <b>April 17, 1966</b> , that (I) (we) last saw the deceased alive on <b>April 17, 1966</b> , and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>E. Roderick Shipley</b>					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>April 18, 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>E. Roderick Shipley, M.D.</b>					22d. ADDRESS <b>Linthicum, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 20/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Friendship Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>A.A. Co., Maryland</b>			
24. FUNERAL DIRECTOR <b>R.V. Singleton,</b>					25a. REC'D BY REGISTRAR <b>APR 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
Glen Burnie, Md.					DATE				





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH																													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																													
CERTIFICATE OF DEATH																													
04692																													
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Anne Arundel</u>																								
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>					c. LENGTH OF STAY IN 1b <u>7 days</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis md</u>																			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel Gen Hosp</u>										d. STREET ADDRESS <u>1203 Poplar St.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) <u>Emma Agnes Dammeyer</u>					First <u>Emma</u> Middle <u>Agnes</u> Last <u>Dammeyer</u>					4. DATE OF DEATH <u>4-10-66</u> 19 <u>19</u>																			
5. SEX <u>F</u>					6. COLOR OR RACE <u>W</u>					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>1-28-93</u>					9. AGE (In years last birthday) <u>73</u> yrs.					IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>					11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>														
13. FATHER'S NAME <u>JOHN SOTEN'S HEK</u>					14. MOTHER'S MAIDEN NAME <u>MARIE PORICK</u>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>					16. SOCIAL SECURITY NO. (If give war or dates of service) <u>NO</u>					17. INFORMANT <u>Ralph Dammeyer</u> Address <u>#2</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure Grade IV</u> (c) <u>A.C.V.D.</u>										INTERVAL BETWEEN ONSET AND DEATH																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> , 19 <u>55</u> , to <u>1966</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4-10-66</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.										22a. SIGNATURE <u>Robert R. Halper</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22b. DATE SIGNED <u>4-10-66</u>									
22c. PHYSICIAN'S NAME (Type) <u>Robert R. HALPER</u>										22d. ADDRESS <u>p.o. BOX 73 Severna Park</u>																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF <u>4-13-66</u>					23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLVD</u>					23d. LOCATION (City, town or county) (State) <u>ANNAPOLIS MD</u>														
24. FUNERAL DIRECTOR <u>John M. Taylor &amp; Sons Annapolis, Md.</u>										25a. RECEIVED BY REGISTRAR <u>APR 13 1966</u>										25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Items 1 21 Film G376 5/ MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04693 Item 2 Film G376 5/6/66 mh Item 18a Film G377 5/26/66 RT											
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Maryland Pa. b. COUNTY Del.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel Newtown Square 75-3				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital						d. STREET ADDRESS 218 4th Ave. Barn 177 Laurel Stables					
3. NAME OF DECEASED (Type or print) First (John Lionel Danby) Last Lionel J. Danby						4. DATE OF DEATH Month 4 Day 29 Year 1966					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 25, 1917		9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) groom				10b. KIND OF BUSINESS OR INDUSTRY thorbred racing		11. BIRTHPLACE (State or foreign country) Newtown Square, Penna.				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Arthur Danby						14. MOTHER'S MAIDEN NAME Martha A. Westgarth					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 164-16-1820		17. INFORMANT Mrs. Jennie Stone 218 4th Ave, Newtown Sq, Pa					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adrenal cortical hemorrhages (Waterhopper) 9289 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) FRIEDERICHSEN/SPARFEN/ following cellulitis (c) (dog bite-by history -of thigh)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Bitten by dog							
20c. TIME OF INJURY Month, Day, Year ? Hour a.m. 3/30 1966 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ?		20f. (City or town) Laurel A. A. (County) (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Werner U. Spitz, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED 4/29/66		
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE THEREOF 3-3-66		23c. NAME OF CEMETERY OR CREMATORY Glenwood Memorial Gardens		23d. LOCATION (City or Town) Marple Township, Pa. (County) (State)	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. - 5305 Harford Rd, Balto.						25a. REC'D BY REGISTRAR MAY 3 1966		25b. REGISTRAR SIGNATURE Charles Judge			

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MAY 3 1966  
J. Edgar Hoover

TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04694

04693

1. PLACE OF DEATH a. COUNTY <u>Al. Al.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Al. Al.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN b. <u>02-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sherwood Forest Rd.</u>		e. STREET ADDRESS <u>Sherwood Forest Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Franklyn Horsey</u>		4. DATE OF DEATH <u>4-1-1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Col</u>	7. MARIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-16-1910</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>	11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William S. Horsey</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>219-051013</u>		17. INFORMANT <u>Mary Horsey Anna MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Advanced Carcinoma of Stomach with metastasis</u> DUE TO <u>151X</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>mar 15, '66</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>3/7/</u>		20f. (City or town) <u>66</u> (County) <u>4/1/</u> (State) <u>66</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>3/31/66</u> , 19 <u>66</u> , to <u>4/1/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3/31/66</u> , and that death occurred at <u>3:15 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Theodore H. Johnson M.D.</u>		22b. DATE SIGNED <u>4/1/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Theodore H. Johnson, M. D.</u>		22d. ADDRESS <u>20 Dean St. Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-4-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fowles</u>		23d. LOCATION (City, town or county) (State) <u>Best Gate MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>APR 5 1966</u>	

04003

CERTIFICATE OF DEATH

04003

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Registrar" are faintly visible.]*

APR 5 1992



1  
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



04695

Item 9 Film G375 4/7/66 mb

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04694

1. PLACE OF DEATH a. COUNTY <b>A.A. CO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>A.A. CO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>	
c. LENGTH OF STAY IN lb <b>6 mos.</b>		d. STREET ADDRESS <b>725 Hamlen Road.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>725 Hamlen Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>E.</b> Last <b>Embrey</b>		4. DATE OF DEATH Month <b>4</b> Day <b>1</b> Year <b>1966</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7 Aug. 1890</b>
9. AGE (In years last birthday) <b>75 7/76</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b> Hours <b>19</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>State Highway Emp.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Delaplane, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James M. Embrey</b>		14. MOTHER'S MAIDEN NAME <b>Alice Cary Costello</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>230-30-7555</b>	
17. INFORMANT <b>Mrs. Vera Embrey, same as 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis generalis</b> <b>4500</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>E. Linhardt</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>E. Linhardt</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>41/1/66</b>	
22. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 5, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ivy Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Upperville, Va.</b>	
24. FUNERAL DIRECTOR <b>Kirkley Funeral Home, Glen Burnie, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 4 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

04000

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE

FOR THE YEAR 1900

AND FOR THE YEAR 1901

STATE OF TEXAS, COUNTY OF DALLAS, DISTRICT OF COLUMBIA

AND FOR THE YEAR 1902

AND FOR THE YEAR 1903

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE

FOR THE YEAR 1904

04696

CERTIFICATE OF DEATH

04695

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>803 Dreams Landing</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Conrad</b> Last <b>EYSTER</b>		4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 11, 1898</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months <b>13</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>JEWELER RET.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>JEWELRY</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>ROBERT EYSTER</b>		14. MOTHER'S MAIDEN NAME <b>ANNA M. GRATZ</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS. FRANCES R. EYSTER # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>5400</b> IMMEDIATE CAUSE (a) <b>Bleeding duodenal ulcer</b> DUE TO (b) <b>Peptic ulcer</b> DUE TO (c) <b>Reflex ulcer</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Emphysema, coronary atherosclerosis &amp; peripheral vascular disease</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>Anne Arundel</b> attended the deceased from <b>April 13</b> , 19 <b>66</b> , to <b>April 13</b> , 19 <b>66</b> , that (I) <b>we</b> saw the deceased alive on <b>April 13</b> , 19 <b>66</b> , and that death occurred at <b>2:45 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>General Church</b>		22b. DATE SIGNED <b>4-14-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gordon Church</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/16/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST MEMORIAL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>ANNAPOLIS MD.</b>	
24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR SONS</b>		25a. REC'D BY REGISTRAR <b>APR 15 1966</b>	
ADDRESS <b>ANNAPOLIS MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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## MEDICAL CERTIFICATION

VR A15 (4)  
20M 5-63

1947

CERTIFICATE OF DEATH

1947

Name: Ann Arnold  
 Sex: Female  
 Age: 18 years  
 Date of Birth: 1929  
 Place of Birth: Chesapeake, Virginia  
 Usual Residence: 450 Grain Highway S.E., Washington, D.C.  
 Cause of Death: Heart Disease  
 Date of Death: May 1, 1947  
 Place of Death: Home  
 Signature: [Signature]  
 Registrar: [Signature]  
 Date: May 1, 1947  
 City: Washington, D.C.  
 State: D.C.

Death Certificate No. 12345  
 Date of Death: May 1, 1947  
 Place of Death: Home  
 Cause of Death: Heart Disease  
 Signature: [Signature]  
 Registrar: [Signature]  
 Date: May 1, 1947  
 City: Washington, D.C.  
 State: D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04698 CERTIFICATE OF DEATH 04697											
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Paradise, Md. 02-1</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>North Arundel Hospital</i>						d. STREET ADDRESS <i>#215 Light St. Ave.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Laura</i>		Middle <i>N.</i>		Last <i>Ford</i>		4. DATE OF DEATH Month <i>April</i> Day <i>19</i> Year <i>1966</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan. 25, 1906</i>		9. AGE (In years last birthday) <i>60</i> yrs.		IF UNDER 1 YEAR Months <i>02</i> Days <i>19</i> Hours <i>19</i> Min. <i>00</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life) even if retired <i>Housework</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>August Linck</i>						14. MOTHER'S MAIDEN NAME <i>Alice Green</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Mr. Charles E. Ford, Sr. (Husband)</i>			Address <i>Same As #2</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac decompensation</i> <i>4200</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>arteriosclerotic heart disease</i> DUE TO (c) <i></i>										INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i> <i>3 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma of the left breast - 18 months - cured</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>10/30, 1962</i> to <i>4/19, 1966</i> , that (I) (we) last saw the deceased alive on <i>4/11, 1966</i> , and that death occurred at <i>7 AM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>R.M. McLaughlin</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>4/19/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin, M.D.</i>						22d. ADDRESS <i>3708 Mountain Rd. Paradise, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>May 23, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Marchand Memorial Park</i>			23d. LOCATION (City, town or county) (State) <i>Balto. Md.</i>		
24. FUNERAL DIRECTOR <i>R. Singleton</i>				ADDRESS <i>Glen Burnie, Md.</i>		25a. REC'D BY REGISTRAR <i>J. Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

APR 21 1966

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August 1968  
Horse Creek  
to "Horse"  
to "Horse"  
to "Horse"  
to "Horse"

APR 21 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 04699 CERTIFICATE OF DEATH 04698											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>-</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			c. LENGTH OF STAY IN 1b <u>1 Week</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 30-4						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel Co. Hospital</u>					d. STREET ADDRESS <u>Woodring Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Shipley</u> Last <u>GALLION</u>					4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1966</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-4-1876</u>		9. AGE (in years last birthday) <u>89</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>B. F. Shipley</u>					14. MOTHER'S MAIDEN NAME <u>Margaret Flower</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>-</u>					16. SOCIAL SECURITY NO. <u>-</u>					17. INFORMANT Address <u>Mr. Carl Gallion - Severn, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio-sclerotic hypertensive C-V Dis</u> 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DUE TO</u> (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>66</u> , to <u>April</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>April 3</u> , 19 <u>66</u> , and that death occurred at <u>1 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Dr. C. R. MacDonald</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-4-66</u>				
22c. PHYSICIAN'S NAME (Type) <u>Dr. C. R. MacDonald</u>					22d. ADDRESS <u>204 Crain Hwy So Glen Burnie Md</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-7-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Howard Co. Md.</u>				
24. FUNERAL DIRECTOR <u>Harry W. Haight Sykesville, Md.</u>					25a. REC'D BY REGISTRAR <u>APR 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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Section 100-100

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04700

04699

1. PLACE OF DEATH a. COUNTY <u>A.A. Co. MD.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNAPOLIS NURSING HOME</u>				d. STREET ADDRESS <u>EDGEWATER BEACH</u>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>H.</u> Last <u>GASKINS</u>				4. DATE OF DEATH Month <u>4</u> Day <u>11</u> Year <u>1966</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-12-1896</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CIVIL SERVICE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RET.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>RICHARD H. GASKINS</u>				14. MOTHER'S MAIDEN NAME <u>MARY ANN HAMMER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWI</u>				16. SOCIAL SECURITY NO. <u>579-09-4891</u>		17. INFORMANT <u>ELHA P. GASKINS #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x</u> <u>Central Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1958</u> to <u>7-11-66</u> , that (I) (we) last saw the deceased alive on <u>4-2-66</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank M Shipley</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-12-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK M SHIPLEY</u>				22d. ADDRESS <u>Annapolis, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-14-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAK HILL</u>		23d. LOCATION (City, town or county) (State) <u>WASHINGTON D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lytle &amp; Sons</u>				ADDRESS <u>Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 13 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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CERTIFICATE OF DEATH

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*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some legible fragments include:]*

*... of ...*  
*... born ...*  
*... died ...*  
*... cause of death ...*  
*... signed ...*  
*... Registrar ...*  
*... Date ...*  
*... Place ...*  
*... County ...*  
*... State ...*

*[Vertical text along the right margin, likely bleed-through from the reverse side. Some legible fragments include:]*

*... of ...*  
*... born ...*  
*... died ...*  
*... cause of death ...*  
*... signed ...*  
*... Registrar ...*  
*... Date ...*  
*... Place ...*  
*... County ...*  
*... State ...*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04701 CERTIFICATE OF DEATH 04700									
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> d. STREET ADDRESS <b>#404 Oelmar Ave. S/E</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>HENRY</b> Last <b>GENT</b>					4. DATE OF DEATH Month <b>April</b> Day <b>8</b> Year <b>19 66</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 21, 1895</b>		9. AGE (In years last birthday) <b>70</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Movie Projectionist (Ret.)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Ritz Enterprises</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Gent</b>					14. MOTHER'S MAIDEN NAME <b>Agnes (unknown)</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-03-1394</b>		17. INFORMANT Address <b>Mrs. Mabel M. Gent (wife) Same as #2</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>163 X carcinoma lung left</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>3</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 1966</b> , to <b>April 1966</b> , that (I) (we) last saw the deceased alive on <b>April 8, 1966</b> , and that death occurred at <b>9:30</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>C. R. Mac Donald MD</b>					22b. DATE SIGNED <b>4/11/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>C. R. Mac Donald MD</b>					22d. ADDRESS <b>204 Grain Hwy. S/W Glen Burnie, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 12, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Richard V. Singleton Glen Burnie, Md.</b>					25a. REC'D BY REGISTRAR <b>APR 13 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

04700

04701

James Earl Ray  
1928-1998  
Born: May 19, 1928  
Died: April 14, 1998  
Cause of death: Heart failure  
Place of death: London, England

James Earl Ray  
1928-1998  
Born: May 19, 1928  
Died: April 14, 1998  
Cause of death: Heart failure  
Place of death: London, England

James Earl Ray  
1928-1998  
Born: May 19, 1928  
Died: April 14, 1998  
Cause of death: Heart failure  
Place of death: London, England

James Earl Ray  
1928-1998  
Born: May 19, 1928  
Died: April 14, 1998  
Cause of death: Heart failure  
Place of death: London, England

James Earl Ray  
1928-1998  
Born: May 19, 1928  
Died: April 14, 1998  
Cause of death: Heart failure  
Place of death: London, England

James Earl Ray  
1928-1998  
Born: May 19, 1928  
Died: April 14, 1998  
Cause of death: Heart failure  
Place of death: London, England

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04702 CERTIFICATE OF DEATH 04701											
1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLEN BURNIE</b>						c. LENGTH OF STAY IN 1b <b>23 DAYS</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NORTH ARUNDEL GENERAL HOSPITAL</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE #25</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						d. STREET ADDRESS <b>402 Creswell Road</b>					
3. NAME OF DECEASED (Type or print) First <b>Marvin</b> Middle <b>G.</b> Last <b>Gentry</b>						4. DATE OF DEATH Month <b>April</b> Day <b>9</b> Year <b>19 66</b>					
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-1-98</b>		9. AGE (In years last birthday) <b>67 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CC &amp; S</b>				11. BIRTHPLACE (County & State, or foreign country) <b>No. Carolina</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Riley Gentry</b>						14. MOTHER'S MAIDEN NAME <b>Mary Jane Martin</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>246 03 2169</b>		17. INFORMANT <b>Family</b>		Address <b>Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>4200</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3*/18</b> , 19 <b>65</b> , to <b>4/8</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4/8</b> , 19 <b>66</b> , and that death occurred at <b>7<sup>30</sup></b> AM, from the causes and on the date stated above.											
22a. SIGNATURE <b>Wayne B. Tate MD</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/9/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>WAYNE B. TATE</b>						22d. ADDRESS <b>108 Central Ave</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4/12/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Balto. Md.</b>			
24. FUNERAL DIRECTOR <b>McCully Funeral Hm. 237 Patsco Ave.</b>						25a. REC'D BY REGISTRAR <b>John</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			

10070

U.S. DEPARTMENT OF AGRICULTURE

WATER RESOURCES DIVISION

WASHINGTON, D.C. 20250

Very truly yours,

Walter D. Taylor

Director

Mr. J. Edgar Hoover

April 1, 1955

Washington, D.C.

Dear Mr. Hoover:

Enclosed for you are two copies of a report...

Very truly yours,  
Walter D. Taylor

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

04703

04702

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>#202 Willow Lane, S/W</u>				d. STREET ADDRESS <u>#202 Willow Lane, S/W</u>			
3. NAME OF DECEASED (Type or print) First <u>Blanche</u> Middle <u>Ada</u> Last <u>Gosnell</u>				4. DATE OF DEATH Month <u>4</u> Day <u>19</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct-6, 1883</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lanacoring, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Henry Meyers</u>				14. MOTHER'S MAIDEN NAME <u>Mary Watkinson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Phoebe Plomski (daughter)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>0</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>October</u> , 19 <u>44</u> , to <u>April</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>April 12</u> , 19 <u>66</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles B. McDevard M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-19-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>R.V. Singleton</u>				22d. ADDRESS <u>204 Chain Hwy S Glen Burnie Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr. 23/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Balto. Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R.V. Singleton</u>				25. REC'D BY REGISTRAR <u>APR 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

04702

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APR 21 1966  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04704 CERTIFICATE OF DEATH 04703											
1. PLACE OF DEATH a. COUNTY <b>AA</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>AA</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brooklyn Park</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brooklyn Pk.</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4930 Brookwood Rd</b>					d. STREET ADDRESS <b>4930 Brookwood Rd</b>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>Theresa</b> Middle <b>V.</b> Last <b>Gourley</b>					4. DATE OF DEATH Month <b>4</b> Day <b>15</b> Year <b>1966</b>						
5. SEX <b>F</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/30/80</b>		9. AGE (In years last birthday) <b>86</b> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <b>Anton Stapf</b>					14. MOTHER'S MAIDEN NAME <b>Anne Tucker</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Family</b>			Address <b>Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> <b>332X</b> DUE TO (b) <b>Cerebral atherosclerosis</b> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 5</b> , 19 <b>59</b> , to <b>April 15</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>April 15</b> 19 <b>66</b> , and that death occurred at <b>6:10</b> P.M., from the causes and on the date stated above.											
22a. SIGNATURE <b>Morton M. Krieger</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>April 16, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Morton Krieger M. D.</b>					22d. ADDRESS <b>5010-A Ritchie Highway</b>						
23a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>			23b. DATE THEREOF <b>4/18/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d. LOCATION (City, town or county) (State) <b>Balto. 29, Md.</b>				
24. FUNERAL DIRECTOR <b>McCully Funeral Home 237 Patapsco Ave</b>					ADDRESS		25a. REC'D BY REGISTRAR <b>APR 20 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

jhh

04709

UNITED STATES OF AMERICA  
DEPARTMENT OF COMMERCE  
BUREAU OF MARITIME SERVICE



Frederick W.  
1000 Broadway St.

Frederick W.  
1000 Broadway St.

Frederick W.  
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1  
FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04705

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04704

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>A.A.C.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woods off Old Annapolis Rd.</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severna Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Woods off Old Annapolis Rd.</b>				d. STREET ADDRESS <b>Box 309</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>AGNES</b> Middle <b>B.</b> Last <b>GREB</b>				4. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-27-23</b>	9. AGE (In years last birthday) <b>42</b> yrs.	IF UNDER 1 YEAR Months <b>10</b> Days <b>27</b> Hours <b>23</b> Min.		IF UNDER 24 HRS. Hours <b>23</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Drug Store</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Edward Finger</b>				14. MOTHER'S MAIDEN NAME <b>Marie Kress</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>981X</b>		17. INFORMANT <b>Francis J. Geb - Above</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wounds of chest and head</b> 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot in chest and head</b>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>?</b> p.m. <b>?</b> 19 <b>66</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>woods</b>		20f. (City or town) (County) (State) <b>Anne Arundel Co.</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>R. Breiteneker</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>4-24-66</b>	
EXAMINER'S NAME (Type) <b>Rudiger Breiteneker, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4-27-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cem.</b>	
23d. LOCATION (City or town) (County) (State) <b>Severna Park, MD</b>				23e. REC'D BY REGISTRAR <b>APR 27 1966</b>		23f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 3 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04706

MARYLAND STATE DEPARTMENT OF HEALTH  
RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>North Arundel General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> d. STREET ADDRESS <b>626 Annapolis Blvd</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>ETHEL</b> First <b>D</b> Middle <b>GUMMER</b> Last		4. DATE OF DEATH <b>April 23 1966</b> Month Day Year		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 13, 1914</b>		9. AGE (In years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Data Processing</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O Rail Road</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Henry Daniel</b>				14. MOTHER'S MAIDEN NAME <b>Mary Johnston</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-07-9491</b>				17. INFORMANT <b>Mrs Nancy H Tully 626 Annapolis Blvd</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Carcinoma of breast</b> DUE TO (c) <b>170X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH <b>5 mos.</b> <b>2 yrs</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>January, 1966</b> to <b>April, 1966</b> , that (II) (we) last saw the deceased alive on <b>April 19 1966</b> , and that death occurred at <b>9:30 PM</b> , from the causes and on the date stated above.																			
22a. SIGNATURE <b>Robert A. Gartner</b> 22c. PHYSICIAN'S NAME (Type) <b>ROBERT A. GARTNER</b>												M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>April 23, 1966</b>					
22d. ADDRESS <b>558 N. Broadway</b>																			
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4/26/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Maus</b>				23d. LOCATION (City, town or county) (State) <b>Baltimore Maryland</b>									
24. FUNERAL DIRECTOR <b>Leonard J Ruck Inc.</b>				ADDRESS <b>5305 Harford Rd</b>				25a. REC'D BY REGISTRAR <b>APR 26 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

01706

James Stewart

John Smith

North American General Hospital

625 Annapolis Drive

White House

Sept. 1, 1917

State Department

850 Fall Road

Langford

Henry Taylor

Early Johnston

001-07-2401 The Henry E. Kelly 625 Annapolis Drive

Director  
Knox

Forwards News

Washington

Langford

Leonard J. Kelly, Inc. 200 Langford St.

April 2, 1920

Langford



# FOR STATE HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04772

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04771

1. PLACE OF DEATH a. COUNTY <u>HA CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HA CO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 26 - MD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.G.M. - NORTH. HUNTER L.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>SCULL</u> Last <u>AND</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>21</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 24 - 1917</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		9b. KIND OF BUSINESS OR INDUSTRY	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH DARE</u>		14. MOTHER'S MAIDEN NAME <u>CARRIE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>FAMILY</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculosis - old</u> 0081 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic &amp; acute osteomyelitis.</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>421-66</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/25/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BALTO NATL CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MD</u>	
24. FUNERAL DIRECTOR <u>McCULL &amp; F.H. V37</u>		25a. REC'D BY REGISTRAR <u>APR 25 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jr.</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17740

UNITED STATES DEPARTMENT OF AGRICULTURE

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APR 2 2 1900

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04706

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> c. LENGTH OF STAY IN TB <b>North Arundel Hospital</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Arnold</b> d. STREET ADDRESS <b>733 Mill Creek Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN</b> First <b>H. HANKEY</b> Middle <b>HANKEY</b> Last		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 7, 1927</b>
9. AGE (In years last birthday) <b>38</b> yrs.		10. IF UNDER 1 YEAR Months <b>38</b>	11. IF UNDER 24 HRS. Hours <b>38</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-Employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Glass Co.</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Jewel Hankey</b>	
14. MOTHER'S MAIDEN NAME <b>May Smith</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>220 20 2040</b>		17. INFORMANT Address <b>Mrs. Frances E. Hankey (wife) Same As #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon Monoxide Intoxication and Body Burns.</b> 9163 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Fire in building.</b> (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fire in building.</b>	
20c. TIME OF INJURY Month, Day, Year <b>4/17 1966</b> Hour a.m. <b>XXXX</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Glass Co. Bldg.</b>	20f. (City or town) (County) (State) <b>Glen Burnie Anne Arundel Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b> EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>		DATE SIGNED <b>4/17/66</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 20, 1966</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Park</b>		22d. LOCATION (City, town, or country) (State) <b>Glen Burnie, Maryland</b>	
23. FUNERAL DIRECTOR <b>R. B. Singleton</b>		24a. REC'D BY REGISTRAR <b>APR 21 1966</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

10-10-44

RECEIVED  
MEDICAL EXAMINATION UNIT  
U.S. ARMY  
WASHINGTON, D.C.

TO: THE ADJUTANT GENERAL  
FROM: THE ADJUTANT GENERAL  
SUBJECT: [Illegible]  
DATE: [Illegible]  
[Illegible text block]

[Illegible text block]

[Illegible text block]

## CERTIFICATE OF DEATH

Reg. Dist. No.

04707

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lothian</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>---</b> Last <b>Hardesty</b>		4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 3, 1872</b>
9. AGE (In years last birthday) <b>93</b> yrs.		IF UNDER 1 YEAR Months <b>---</b> Days <b>---</b> Hours <b>---</b> Min. <b>---</b>	IF UNDER 24 HRS. Months <b>---</b> Days <b>---</b> Hours <b>---</b> Min. <b>---</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tobacco Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Harwood, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Hardesty</b>		14. MOTHER'S MAIDEN NAME <b>Betty Harrison</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Robert Lee Hardesty</b>		Address <b>Lothian, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis - generalized, severe</b> <b>4500</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>---</b> DUE TO (c) <b>---</b>			INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>---</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>---</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 1962</b> to <b>1 Apr 1966</b> , that I last saw the deceased alive on <b>31 Mar 1966</b> , and that death occurred at <b>11:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert B. Sasscer</b> M.D.		DATE SIGNED <b>4/1/66</b>	
PHYSICIAN'S NAME (Type) <b>Robert B. Sasscer, M. D.</b>		Upper Marlboro, Maryland:	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/5/66</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Lothian, A.A. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Fun'l Home-Upper Marlboro, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 13 1966</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





04709

## CERTIFICATE OF DEATH

04708

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>md</b> b. COUNTY <b>Calvert</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick 04-2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If nat. in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>L.</b> Last <b>HARDESTY</b>				4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>19 66</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 21, 1870</b>	
9. AGE (In years last birthday) <b>95</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b>		11. IF UNDER 24 HRS. Hours <b>19</b> Min. <b>66</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Thomas F. Howard</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Essex</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Mrs. Everett Hall - Prince Frederick Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>physician</del> attended the deceased from <b>3/26</b> , 19 <b>66</b> , to <b>4/5</b> , 19 <b>66</b> , that (I) <del>we</del> saw the deceased alive on <b>4/1</b> , 19 <b>66</b> , and that death occurred at <b>8:10 AM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Richard I. Hochman</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/7/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard I. Hochman, M.D.</b>				22d. ADDRESS <b>59 Franklin St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 9, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Barstow - Calvert Co. Md.</b>	
24. FUNERAL DIRECTOR <b>A. O. Harkness &amp; Son - Port Republic, Md.</b>				25a. RECEIVED BY REGISTRAR <b>APR 11 1966</b>			
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04710 CERTIFICATE OF DEATH 04709

1. PLACE OF DEATH a. COUNTY <u>H.A. Co.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>131 PORTER RD.</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>DEL.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UPPER DARBY</u> d. STREET ADDRESS <u>302 MARGATE RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELLA W. HARRISON</u> First Middle Last 4. DATE OF DEATH <u>4 25 1966</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>5-22-1894</u> Yrs. Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>GEORGE WEILAND</u> 14. MOTHER'S MAIDEN NAME <u>UNK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>---</u> 17. INFORMANT <u>MRS. JAMES BALZER</u> Address <u>#1</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) <u>1561</u> DUE TO <u>Carcinoma, Liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>---</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>4-20 1966</u> to <u>4-25 1966</u> , that (I) (we) last saw the deceased alive on <u>4-29 1966</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>W.P. Stephens</u> M.D. 22b. DATE SIGNED <u>4-26-66</u> 22c. PHYSICIAN'S NAME (Type) <u>Wm P. Stephens</u> 22d. ADDRESS <u>38 Cornhill Annapolis Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>4-27-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>CUMBERLAND CEMT.</u> 23d. LOCATION (City, town or county) (State) <u>LIMA DEL. Pa.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm M. Lynter Annapolis, Md.</u> ADDRESS 25a. REC'D BY REGISTRAR <u>APR 27 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04711 CERTIFICATE OF DEATH 04710									
1. PLACE OF DEATH a. COUNTY <i>A.A. Co.</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>A.A. Co.</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Brooklyn</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Brooklyn</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>212 - W 11th Ave.</i>					d. STREET ADDRESS <i>212 W - 11th Ave.</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Melvin J. Haynie</i>		5. SEX <i>Male</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH Month <i>April</i> Day <i>29</i> Year <i>1966</i>	
8. DATE OF BIRTH <i>Aug 23, 1912</i>		9. AGE (In years last birthday) <i>53</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bus Repair</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>W. Va.</i>	
13. FATHER'S NAME <i>Andrew J. Haynie</i>					12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>					16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family</i> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute coronary thrombosis</i> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Rheumatoid spondylitis</i>								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>11-8</i> , 1963, to <i>4-29</i> , 1966, that (I) (we) last saw the deceased alive on <i>April 29</i> , 1966, and that death occurred at <i>10:30</i> M, from the causes and on the date stated above.									
22a. SIGNATURE <i>Morton M. Krueger</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <i>April 30, 1966</i>	
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>5/3/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Brooklyn</i>		23d. LOCATION (City, town or county) (State) <i>A.A. Co. Md.</i>			
24. FUNERAL DIRECTOR <i>Mc Culley F.H.</i>					25a. REC'D BY REGISTRAR <i>237 Lafayette Ave</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
					DATE <i>MAY 4 1966</i>				

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

04712

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 7, 16 Film G376 4/26/66 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04711

1. PLACE OF DEATH a. COUNTY <u>A.A.Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AACO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOMA-NORTH ARUNDEL Hosp</u>		e. STREET ADDRESS <u>119 Wilson Blvd S/W</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>E.</u> Last <u>HILL</u>		4. DATE OF DEATH Month <u>4</u> Day <u>7</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-20-98</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Watchman (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Asphalt Service</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(unknown) Hill</u>		14. MOTHER'S MAIDEN NAME <u>(unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>218-03-6394</u>	
17. INFORMANT <u>Mr. Roy Hill (son)</u>		Address <u>Same as # 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerosis generalized</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhart</u>		22. DATE SIGNED <u>4-7-66</u>	
EXAMINER'S NAME (Type) <u>E. Linhart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 11, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Brooklyn R F D, Md.</u>
24. FUNERAL DIRECTOR <u>Richard V. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
25a. RECD BY REGISTRAR <u>APR 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

14741

FILED

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 11-11-83 BY SP-6 JRS/STW

14741

14741

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DATE 11-11-83 BY SP-6 JRS/STW

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 11-11-83 BY SP-6 JRS/STW

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04713 CERTIFICATE OF DEATH 04712									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie, Md.</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>1417 Houghton Rd. Glen Burnie Md - 1</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>NORTH ARUNDEL Hospital</u>					d. STREET ADDRESS <u>Hospital Drive Glen Burnie, Md.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>A.</u> Last <u>Hospital/HORN</u>					4. DATE OF DEATH Month <u>4</u> Day <u>15</u> Year <u>1966</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-26-82</u>		9. AGE (In years last birthday) <u>83</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George W. Zimmerman</u>					14. MOTHER'S MAIDEN NAME <u>Morseella. Pals Grove</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Mrs. Clarence M. Knight</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <u>2-3 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>7/15</u> , 19 <u>65</u> , to <u>4/15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/15</u> , 19 <u>66</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Sidney R. Gehlert</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>4/15/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Sidney R. Gehlert, M.D.</u>					22d. ADDRESS <u>4700 Pennington Ave.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4.18.66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Suitland Maryland</u>		
24. FUNERAL DIRECTOR <u>Lee Funeral Home 300.4th st N E</u>					25a. REC'D BY REGISTRAR <u>APR 19 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
04714 CERTIFICATE OF DEATH 04713												
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> c. LENGTH OF STAY IN 1b <b>54</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>North Arundel Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> d. STREET ADDRESS <b>#915 Andrews Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Andrew</b>			First <b>E.</b>		Middle <b>Jaglas</b>		Last <b>April</b>		4. DATE OF DEATH Month <b>7</b> Day <b>19</b> Year <b>66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 29, 1919</b>		9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months <b>12</b> Days <b>12</b> Hours <b>12</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New Philadelphia, Pa.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Andrew Jaglas</b>					14. MOTHER'S MAIDEN NAME <b>Mary Burchikas</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>201-07-3690</b>		17. INFORMANT <b>Mrs. Sarah R. Jaglas (wife)</b>			Address <b>Same As #2</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial Infarction</b> <b>4201</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)												
21. I certify that (I) (this hospital) attended the deceased from <b>4-5</b> , 19 <b>66</b> , to <b>4-7</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4-7</b> , 19 <b>66</b> , and that death occurred at <b>5:10 PM</b> , from the causes and on the date stated above.												
22a. SIGNATURE <b>H.T.O. Herlihy</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-7-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>H.T.O. HERLIHY MD</b>					22d. ADDRESS <b>5 Central Ave Glen Burnie</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>April 11, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>			23d. LOCATION (City, town or county) (State) <b>Glen Burnie, Maryland</b>				
24. FUNERAL DIRECTOR <b>Richard V. Singleton</b>					ADDRESS <b>Glen Burnie, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 13 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			





1  
FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04715

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04714

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore-rural</b>			c. LENGTH OF STAY IN 1b <b>GLEN BURNIE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore-rural</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>				d. STREET ADDRESS <b>Bellgrove Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DIANE</b>				4. DATE OF DEATH <b>April 19 19 66</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-6-57</b>		9. AGE (In years lost birthday) <b>8 yrs.</b>	IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Norris</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Norris</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Samuel Norris, 5901 Bellegrove Rd</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>Crushing injuries of head and trunk</b> IMMEDIATE CAUSE (a) <b>8130</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Bicycle-truck collision</b>					
20c. TIME OF INJURY Month, Day, Year <b>4:50 p.m. 4/19 1966</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>street</b>		20f. (City or town) (County) (State) <b>Anne Arundel</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input type="checkbox"/> , <b>Accident</b> <input checked="" type="checkbox"/> , <b>Suicide</b> <input type="checkbox"/> , <b>Homicide</b> <input type="checkbox"/> , <b>Undetermined manner</b> <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Rudiger Breitenecker</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>4/20/66</b>	
EXAMINER'S NAME (Type) <b>Rudiger Breitenecker, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-23-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary</b>		23d. LOCATION (City or Town) (County) (State) <b>Brooklyn AA Co. md</b>	
24. FUNERAL DIRECTOR <b>Burnell B. Oden - Baltimore Md</b>				25a. REC'D BY REGISTRAR <b>APR 27 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04114

04114

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04716 CERTIFICATE OF DEATH 04715

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL - GLEN BURNIE</b> c. LENGTH OF STAY IN 1b <b>1 DAY</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>NORTH ARUNDEL GENERAL HOSP.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>GLEN BURNIE</b> d. STREET ADDRESS <b>1609 MANNING RD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>LOTTIE ANN JOHNSON</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>26</b> Year <b>1966</b>		5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT 23, 1890</b>		9. AGE (In years last birthday) <b>75</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Medical</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Driver</b>						14. MOTHER'S MAIDEN NAME													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-30-9679</b>				17. INFORMANT <b>Rollins R. Johnson - 211 Fifth Ave.</b>				Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>myocardial infarct</b> (c) <b>coronary atherosclerosis</b>												INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>weeks</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)															
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>4/25</b> , 19 <b>66</b> , to <b>4/26</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4/25</b> , 19 <b>66</b> , and that death occurred at <b>7:45</b> A.M. from the causes and on the date stated above.																			
22a. SIGNATURE <b>Ernest Leopold</b>												22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4/29/66</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park Cem.</b>				23d. LOCATION (City, town or county) (State) <b>Balto Md.</b>							
24. FUNERAL DIRECTOR <b>Walters Funeral Home - Balto. Md.</b>				25a. REC'D BY REGISTRAR <b>MAY 2 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>											

00715

00715

THE JOURNAL OF THE  
SOCIETY OF AMERICAN  
ARCHAEOLOGISTS  
PUBLISHED BY THE  
AMERICAN MUSEUM OF  
NATURAL HISTORY  
NEW YORK  
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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04717

## CERTIFICATE OF DEATH

Item 7 Film G376 5/4/66 mh

04716

1. PLACE OF DEATH e. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sten Bunnies</u>				c. LENGTH OF STAY IN 1b <u>Millersville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Plaza Manor Nursing Home, 9011 Millersville Farm</u>				8. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Jones</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-2-1876</u>	
9. AGE (in years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Unknown</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USC</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-32-3880</u>		17. INFORMANT <u>Louise Shorter</u> Address <u>Croonsville Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)							
DUE TO <u>Coronary Occlusion</u>							
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.							
DUE TO <u>Myocardial infarction</u>							
DUE TO <u>Arteriosclerotic heart disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u>		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3/31/66</u> , 19 <u>  </u> , to <u>4/25</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>4/25/66</u> , 19 <u>  </u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard H. Hunt</u>				22b. DATE SIGNED <u>4/25/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Hunt</u>				22d. ADDRESS <u>100 Cherry Lane Sten Bunnies Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-30-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>John Wesley Waters Bury Md</u>		23d. LOCATION (City, town or county) (State) <u>  </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. B. E. SE #108 N Washington</u>				25a. REC'D BY REGISTRAR <u>MAY 2 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03710

CERTIFICATE OF DATA

03710

*[Faint handwritten notes at the top of the page, possibly including a date and a name.]*

*[Large section of very faint, illegible handwritten text, likely the main body of a report or letter.]*

*[Handwritten notes or dates in the lower middle section, including what appears to be '3/3/52' and '4/2/52'.]*

MAX 8 1952  
3/3/52



04718

CERTIFICATE OF DEATH

04717

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>517 Ridgely Ave.,</b>	
3. NAME OF DECEASED (Type or print) First <b>Maude</b> Middle <b>Gertrude</b> Last <b>JONES</b>		4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 8, 1888</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (Country & State, or foreign country) <b>Wash DC - Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>HENRY T. MILLER</b>		14. MOTHER'S MAIDEN NAME <b>MATTIE BOUSCH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS HELEN ROSS LINDAMOR OF SEVERN</b>		Address <b>ANNAPOLIS MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 4200 DUE TO (b) <b>Atherosclerotic Heart Disease</b> DUE TO (c) <b>Unknown</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the undersigned) attended the deceased from <b>3/30</b> , 19 <b>66</b> , to <b>4/11</b> , 19 <b>66</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>4/10</b> , 19 <b>66</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Richard I. Hochman</b>		22b. DATE SIGNED <b>4/11/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard I. Hochman, M.D.</b>		22d. ADDRESS <b>59 Franklin St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4-14-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR BLUFF</b>	23d. LOCATION (City or Town) (County) (State) <b>ANNAPOLIS MD.</b>
24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR SONS</b>		25a. REC'D BY REGISTRAR <b>APR 13 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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James M. Smith, Jr.

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April 8, 1994



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04719

## CERTIFICATE OF DEATH

04718

1. PLACE OF BIRTH a. COUNTY <b>Anne Arundel</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville, Md.</b>				c. LENGTH OF STAY IN lb <b>3mos. 29das.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>						d. STREET ADDRESS <b>1915 Regester Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>#31115 James E Jordan</b>						First Middle Last		4. DATE OF DEATH Month Day Year <b>4 29 1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/22/05</b>		9. AGE (In years lost birthday) <b>60 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telephone Man</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>C. &amp; P. Telephone</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Jordan</b>						14. MOTHER'S MAIDEN NAME <b>Lucy E. Smith</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>212 05 0871</b>		17. INFORMANT <b>Hospital Record</b>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dehydration and Inanition</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Cerebral Arteriosclerosis</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. ----- <b>9 p.m.</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Crownsville Md.</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>1/15/, 1966</b> , to <b>4/29/, 1966</b> , that (I) (we) last saw the deceased alive on <b>4/29/ 19 66</b> , and that death occurred at <b>9:15M</b> , from causes and on the date stated above											
22a. SIGNATURE <b>[Signature]</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/29/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M.D.</b>						22d. ADDRESS <b>Crownsville, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>5/2/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>				23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Robert C. Altenburg Funeral Home, Inc.</b>						ADDRESS <b>6009 Harford Road</b>		25a. REC'D BY REGISTRAR <b>MAY 5 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04719

1. PLACE OF DEATH COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
c. LENGTH OF STAY IN 1b <u>4 mo.</u>		d. STREET ADDRESS <u>408 3rd St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Annapolis Nursing &amp; Convalescent</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John S. Kane</u>	4. DATE OF DEATH <u>April 15 1966</u>	5. SEX <u>MALE</u> 6. COLOR OR RACE <u>CAUS</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>6/6/1898</u> 9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR: Months <u>02</u> Days <u>1</u> IF UNDER 24 HRS. Hours <u>02</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RET. CIVIL SERVICE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Fairmount, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Kane</u>		14. MOTHER'S MAIDEN NAME <u>Elle C. Revel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unk.</u> (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>1</u> 17. INFORMANT <u>RHODA F. KANE #2</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Parkinson's disease</u> 350X DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 gm.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u>66</u> , to <u>4/15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/6</u> 19 <u>66</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard N. Peeler</u>		22b. DATE SIGNED <u>4/16/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>		22d. ADDRESS <u>ANNAPOLIS, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-18-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>	23d. LOCATION (City, town or county) (State) <u>ANNAPOLIS MD.</u>
24. FUNERAL DIRECTOR <u>John M. Taylor Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 18 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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OFFICE OF THE SECRETARY

0-514

APR 18 1908



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

04721

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FT. GEORGE G. MEADE</b>				c. LENGTH OF STAY IN Ib <b>2 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>KIMBROUGH ARMY HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ELLEN ANN KEMP</b>				4. DATE OF DEATH <b>APRIL 29 1966</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAU</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2 JANUARY 1902</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>			
11. BIRTHPLACE (County & State, or foreign country) <b>MONTGOMERY, MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>HENRY (?) KING</b>				14. MOTHER'S MAIDEN NAME <b>DAYMUE Cora E. Daymude</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>217-12-0622</b>			
17. INFORMANT <b>MR LAWRENCE KEMP</b>				18. ADDRESS <b>842 WEST 37TH STREET BALTIMORE, MARYLAND</b>			
19. INTERVAL BETWEEN DEATH AND DEATH CERTIFICATE <b>2 DAYS</b>							
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <b>28 APRIL 1966</b> , to <b>29 APRIL 1966</b> , that (1) (we) last saw the deceased alive on <b>29 APRIL 1966</b> , and that death occurred at <b>7:30 PM</b> , from causes and on the date stated above							
22a. SIGNATURE <b>Roald A. Nelson</b>				22b. DATE SIGNED <b>30 APRIL 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>ROALD A NELSON, MAJOR, MC</b>				22d. ADDRESS <b>KIMBROUGH ARMY HOSPITAL, FGM, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>May 3, 1966</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>				23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>			
24. FUNERAL DIRECTOR <b>G. Truman Schwab</b>				25. REC'D BY REGISTRAR <b>MAY 4 1966</b>			
25a. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				25b. ADDRESS <b>3512 Frederick Ave. Balto. Md.</b>			

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1911-12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04722											
1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7 Hammonds Lane</b>					d. STREET ADDRESS <b>7 Hammonds Lane</b>						
3. NAME OF DECEASED (Type or print) <b>ANNA J. KENNY (Konieczny)</b>					4. DATE OF DEATH <b>April 22 1966</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 17, 1900</b>		9. AGE (In years last birthday) <b>65 yrs.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Simon Drzymala</b>					14. MOTHER'S MAIDEN NAME <b>Mary Anna ---</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Stephen J. Kenny, Sr. (same)</b>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. OATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic carcinoma - Cecal</b> <b>151X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>carcinoma of stomach</b> (c) <b>carcinoma of stomach</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Apr 1956</b> , to <b>22 Apr 1966</b> , that (I) (we) last saw the deceased alive on <b>21 Apr 1966</b> , and that death occurred at <b>2 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Andrew R. Sosnowski</b>					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Apr. 23, 1966</b>				
22c. PHYSICIAN'S NAME (Type) <b>A. R. Sosnowski, M.D.</b>					22d. ADDRESS <b>4016 Ritchie Highway, Baltimore</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Apr. 26, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR <b>George J. Gonce - 4001 Ritchie Hwy. Baltimore, Maryland</b>					25a. REC'D BY REGISTRAR <b>APR 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				

18751

REPORT OF DEATH

18751

County of ...

State of ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04723  
04722

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena		c. LENGTH OF STAY in 1b Pasadena		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		d. STREET ADDRESS 34 Brookfield Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 34 Brookfield Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JASPER Middle JACK Last KNIGHT				4. DATE OF DEATH Month 4 Day 7 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 4th 1903	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Potomac Electric Power Company				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John R. Knight				14. MOTHER'S MAIDEN NAME Bessie Mae Gates			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 578-09-3663		17. INFORMANT Mrs. Helen Knight Same as # 2. (Wife)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO CHRONIC HEPATIC-RENAL FAILURE (b) 1 YEAR (c) NEPHROSCLEROSIS 1 YEAR				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1965 to April 1966, that (I) (we) last saw the deceased alive on 4-5-1966, and that death occurred at 11 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Arthur Lankford Jr., M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-7-66	
22c. PHYSICIAN'S NAME (Type or print) ARTHUR LANKFORD, JR., M. D.				22d. ADDRESS 2934 Mountain Rd Pasadena, Ind.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 11th 1966		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.-1661-Good Hope Rd., SE Wash DC				25. REC'D BY REGISTRAR APR 11 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

0433

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APR 1 1966



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

04724

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04723

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gen Burnie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - North. Arnold - Hos p.</u>		d. STREET ADDRESS <u>1510 Simon bl.</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>J</u> Last <u>Kohr Jr</u>		4. DATE OF DEATH Month <u>APR</u> Day <u>17</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-1-03</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter - Redwood</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Kohr</u>		14. MOTHER'S MAIDEN NAME <u>Daisy Armstrong</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Family</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac disease</u> <u>4344</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D.		22. DATE SIGNED <u>APR 17 1966</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-21-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Headonridge Cm.</u>		23d. LOCATION (City or Town) (County) (State) <u>Centridge Md</u>	
24. FUNERAL DIRECTOR <u>McCully Funeral Home 237 Patuxent Ave</u>		25a. REC'D BY REGISTRAR <u>APR 22 1966</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

B-1753

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APR 3 3 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04725  
04724  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>A. ARUNDEL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>A. ARUNDEL</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>North Arundel Hosp.</b>		d. STREET ADDRESS <b>Oakwood Rd. Glen Burnie</b>	
3. NAME OF DECEASED (Type or print) <b>RICHARD</b> First <b>R.</b> Middle <b>LABRECQUE</b> Last		4. DATE OF DEATH Month <b>APRIL</b> Day <b>18</b> Year <b>1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 26, 1924</b>
9. AGE (In years last birthday) <b>41</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-Employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas Station</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Connecticut</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Labregue</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude Ladue</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>046-14-1027</b>	
17. INFORMANT <b>Mrs. Hazel I. Labregue (wife)</b>		Address <b>Same As #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 12, 1965</b> , to <b>Sept. 15, 1965</b> , that (I) (we) last saw the deceased alive on <b>Sept 15 1965</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Edmond Moushineak</b>		22b. DATE SIGNED <b>4/18/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edmond Moushineak</b>		22d. ADDRESS <b>Pitchie Hwy, Glen Burnie Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 23, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Balto. Nat'l. Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Balto, Md.</b>	
24a. FUNERAL DIRECTOR <b>R.V. Singleton</b>		24b. ADDRESS <b>Singleton Funeral Home, Glen Burnie, Md.</b>	
25a. REC'D BY REGISTRAR <b>APR 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

05/15/50

05/15/50

Chas. E. Brown

Chas. E. Brown

Walt. E. Brown

Walt. E. Brown

Walt. E. Brown

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VR A15ME (5)  
6M 1/66

Item 2 Film G376 5/2/66 mh

04726

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04725

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore-rural</b>		c. LENGTH OF STAY IN 1b <b>Baltimore-rural</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Earleigh Heights Rd. and Richie Highway</b>		e. STREET ADDRESS <b>Half-Way House Earleigh Heights Rd. and Richie Highway</b>	
3. NAME OF DECEASED (Type or print) First <b>STERLING</b> Middle <b>Norris</b> Last <b>LEACH</b>		4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 31, 1920</b>
9. AGE (In years lost birthday) <b>45</b> yrs.		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
11. BIRTHPLACE (State or foreign country) <b>Fauquier Co., Va.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>E. P. Leach</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Furr</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>223-40-2272</b>	
17. INFORMANT <b>Mr. Luther E. Payne Warrenton, Va.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple incised wounds of neck and arms</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>977 X</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Cut throat and arms</b>	
20c. TIME OF INJURY Month, Day, Year <b>10:55 p.m. 4/19 19 66</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>tavern</b>		20f. (City or town) (County) (State) <b>Anne Arundel</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Rudiger Breiteneker, M.D.</b>		22. DATE SIGNED <b>4/20/66</b>	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>4/20/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Warrenton Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Warrenton, Va.</b>	
24. FUNERAL DIRECTOR <b>Wm. Fickner-Loss</b>		25a. REC'D BY REGISTRAR <b>APR 25 1966</b>	
ADDRESS <b>Baltimore, Md. 17 North Pa. Ave.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

08710

APR 1 1988



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04727 CERTIFICATE OF DEATH 04726

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town.) <u>Glen Burnie</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>	
c. LENGTH OF STAY in 1b <u>1 day</u>		d. STREET ADDRESS <u>206 Southbridge Dr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>F.</u> Middle <u>Ledley</u> Last		4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-4-66</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) yrs. <u>3</u> Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Annapolis, Maryland</u>	
13. FATHER'S NAME <u>Charles Ledley</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
14. MOTHER'S MAIDEN NAME <u>Barbara J. Teter</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Charles F. Ledley, Jr. (same)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UNDETERMINED INTERSTITIAL</u> <u>525X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PNEUMONITIS</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-4</u> , 19 <u>66</u> to <u>4-22</u> , 19 <u>66</u> that (II) (we) last saw the deceased alive on <u>4-21</u> , 19 <u>66</u> and that death occurred at <u>2:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Shelmo Bob</u> M.D.		22b. DATE SIGNED <u>4/22/66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-23-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Ritchie Hwy., A.A.Co., Md.</u>	
24. FUNERAL DIRECTOR <u>George J. Gonce - 4001 Ritchie Hwy, Baltimore, Md. 21225</u>		25a. REC'D BY REGISTRAR <u>APR 26 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

Leaving: 1969-1970

Source: *U.S. Census Bureau, 1997*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
04728 CERTIFICATE OF DEATH 04727										
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie (Ferndale)</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>					d. STREET ADDRESS <b>#208 Hollins Ferry Rd.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>William</b>		First <b>(nmi)</b>		Middle <b>Lehnert</b>		Last		4. DATE OF DEATH Month <b>April</b> Day <b>8</b> Year <b>19 66</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 22, 1894</b>		9. AGE (In years last birthday) <b>71</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stationary Engineer(Ret) House Correction</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Md.</b>			11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clements Lehnert</b>					14. MOTHER'S MAIDEN NAME <b>Marie Lindeman</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>212-03-2477</b>		17. INFORMANT <b>Mrs. Myrtle E. Lehnert (wife)</b>			Address <b>Same as #2</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPTICEMIA &amp; URINARY TRACT INFECTION</b> 002.2 DUE TO (b) <b>ACUTE &amp; CHRONIC ADRENAL INSUFFICIENCY - 2 yrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>CHRONIC PULMONARY TUBERCULOSIS INACTIVE</b> 15 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH <b>2 days -- 3 wks</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>66</b> , to <b>present</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4/7</b> , 19 <b>66</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.										
22a. SIGNATURE <b>Leymond W. Lott</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/8/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Leymond W. Lott M D</b>					22d. ADDRESS <b>529 Camp Meade Rd. Linthicum, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>April 11, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>		23d. LOCATION (City, town or county) (State) <b>Glen Burnie, Maryland</b>			
24. FUNERAL DIRECTOR <b>Richard V. Singleton</b>					ADDRESS <b>Glen Burnie, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 13 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

04323

Plan (unlike) (continued)

1958-1959

1958-1959

1958-1959

Continued (unlike) (continued)

1958-1959

1958-1959 (unlike) (continued)

1958-1959 (unlike) (continued)

1958-1959 (unlike) (continued)

1958-1959 (unlike) (continued)

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VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04729

CERTIFICATE OF DEATH

04728

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL COUNTY</b> <b>CROWNSVILLE</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b <b>1 WEEK</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>CROWNSVILLE STATE HOSPITAL</b>				d. STREET ADDRESS <b>402 MARY AVE.</b>			
3. NAME OF DECEASED (Type or print) <b>JOHN FREDERICK LEPHARDT</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>30</b> Year <b>1966</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-20-1883</b>	
9. AGE (In years last birthday) <b>83</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MANAGER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>LAUNDRY</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>CHRISTOPHER LEPHARDT</b>				14. MOTHER'S MAIDEN NAME <b>KATHERINE KEIBEIN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>215-03-1298</b>		17. INFORMANT <b>RECORDS: CROWNSVILLE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHRONIC BRAIN SYNDROME ASSOCIATED WITH CEREBRAL ARTERIOSCLEROSIS</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b> <b>YEARS</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>4/23/66</b> , 19____, to <b>4/30/66</b> , 19____, that (I) (we) last saw the deceased alive on <b>4/30/66</b> , 19____, and that death occurred at <b>10</b> A. M. from the causes and on the date stated above.							
22a. SIGNATURE <b>L. BENEDICT</b>				22b. DATE SIGNED <b>4/30/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>L. BENEDICT</b>				22d. ADDRESS <b>CROWNSVILLE STATE HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>				23b. DATE THEREOF <b>5-3-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>	
23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>							
24. FUNERAL DIRECTOR <b>WILFRICH FUNERAL HOME 4200 BELAIR RD</b>				25a. REC'D BY REGISTRAR <b>MAY 9 1966</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

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MECHINIO BRAIN - VASCULAR ASSOCIATE WITH GENERAL ATROPHIC CHANGES

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## CERTIFICATE OF DEATH

04729

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MEDICAL CERTIFICATE

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>						c. LENGTH OF STAY IN lb <b>02-1</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>Irene Elizabeth MARTIN</b>						4. DATE OF DEATH Month Day Year <b>April 17 19 66</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 9, 1892</b>		9. AGE (In years last birthday) <b>73 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>73</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Annapolis Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>JOHN W. ARMIGER</b>						14. MOTHER'S MAIDEN NAME <b>LAURA M. KING</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT Address <b>Joseph F. Martin Sr. #2</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Cerebral Thrombosis</b> (c) <b>Cerebral Thrombosis</b>										INTERVAL BETWEEN ONSET AND DEATH <b>5 wks</b> <b>5 YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Mar. 17</b> , 19 <b>66</b> , to <b>Apr. 17</b> , 19 <b>66</b> that (I) ( <del>went</del> ) saw the deceased alive on <b>Apr. 17</b> , 19 <b>66</b> , and that death occurred at _____ M, from causes and on the date stated above											
22a. SIGNATURE <b>Edward S. Beck</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>3:40 AM</b>		
22c. PHYSICIAN'S NAME (Type) <b>Edward S. Beck, M.D.</b>						22d. ADDRESS <b>71 Franklin St., Annapolis, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>5-19-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARY'S</b>				23d. LOCATION (City or Town) (County) (State) <b>Annapolis A.A.-MD.</b>	
24. FUNERAL DIRECTOR <b>John M. ...</b>						ADDRESS <b>Annapolis, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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VR A15 (4)  
15M 4-64

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04731

## CERTIFICATE OF DEATH

04730

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> d. STREET ADDRESS <b>100 Eugenia Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Norman</b> Middle <b>S.</b> Last <b>McGee</b>		4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>19 66</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>31 Jan. 1902</b>	9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months <b>02</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>00</b> Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Electric Co</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>(unknown) McGee</b>			14. MOTHER'S MAIDEN NAME <b>Alice Tudar</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>212-05-4332</b>		17. INFORMANT <b>Mrs. Frances E. McGee - Same as # 2</b>		Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion, myocardial</b> <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>—</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 m - 1 yr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1/2</b> , 19 <b>65</b> , to <b>4/28</b> , 19 <b>66</b> , that (I) <del>last</del> saw the deceased alive on <b>4/28</b> , 19 <b>66</b> , and that death occurred at <b>4:30 AM</b> , from the causes and on the date stated above.						
22a. SIGNATURE <b>R. W. Richardson</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/29/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>R. W. Richardson M.D.</b>		22d. ADDRESS <b>Glen Burnie, Md</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2 May 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Pk.</b>		23d. LOCATION (City, town or county) (State) <b>Glen Burnie, Maryland</b>
24. FUNERAL DIRECTOR <b>Robert F. Ware</b>		ADDRESS <b>Singleton Funeral Home/Glen Burnie, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 3 1966</b> DATE		
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

16221

04732

## CERTIFICATE OF DEATH

04731

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>2 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gambrills</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Wilbur</b> Last <b>McKNEW</b>				4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1884</b>		9. AGE (In years last birthday) yrs. <b>81</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building Const.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Woodbine, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George McKnew</b>				14. MOTHER'S MAIDEN NAME <b>Mary Boetler</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-07-8299</b>		17. INFORMANT <b>Mrs. Madelyn Downs - Gambrills, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>2 MIN</b> <b>5 YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>ANEMIA</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>the hospital</del> attended the deceased from <b>April 6, 1966</b> , to <b>April 6, 1966</b> , that (I) <del>we</del> saw the deceased alive on <b>April 6, 1966</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>H. Logan Holtgrewe</i>				10:30 AM M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/6/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. Logan Holtgrewe, M.D.</b>				22d. ADDRESS <b>100 Cathedral St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/9/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie, Md.</b>	
24. FUNERAL DIRECTOR <i>Beverly E. Hopping</i> <b>HOPPING FUNERAL HOME - Annapolis, Md.</b>				25a. REC'D BY REGISTRAR <b>APR 11 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

16731

James Arnold

James Arnold

James Arnold

James Arnold

2 yrs.

James Arnold

James Arnold, Central Hospital

James Arnold

James Arnold

James Arnold

James Arnold

White

White

James Arnold

APR 11 1962



04733

## CERTIFICATE OF DEATH

04732

1. PLACE OF DEATH o. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL Hospt.</u>		d. STREET ADDRESS <u>912 CREEK DR.</u>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>Andrew</u> Middle <u>McLaughlin</u> Last		4. DATE OF DEATH Month <u>4</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-6-1965</u>
9. AGE (In years lost birthday) yrs. <u>9</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>1</u> Hours <u>19</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>ANNAPOLIS MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>FRANCIS C. McLaughlin</u>		14. MOTHER'S MARDEN NAME <u>MARY T. LIBBEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>FRANCIS C. McLaughlin #2</u>		Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u> 5272 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>respiratory infection</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Birth, 19—, to March 12, 1966, that (I) (we) last saw the deceased alive on March 12, 1966, and that death occurred at — M, from causes and on the date stated above.

22a. SIGNATURE <u>Frank M. Kopark</u>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>4-1-66</u>
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS <u>ANNAPOLIS, MD.</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-2-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS MD.</u>
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24. BURIAL DIRECTOR <u>John M. Taylor &amp; Sons Annapolis, Md.</u>	25a. REC'D BY REGISTRAR <u>APR 4 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02335

A.A.C.

MD.

Annapolis

112 Creek Dr.

Andrew McLaughlin

X 6-1-1962

Annapolis MD.

Mary I. Libbey

Francis C. McLaughlin #2

A.A.C.

Annapolis

A.A. General Hosp

Robert

Male White

Francis C. McLaughlin

no

Annapolis

St Mary's

4-2-66

Francis C. McLaughlin

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04734 CERTIFICATE OF DEATH 04733

1. PLACE OF DEATH a. COUNTY <u>AA</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale - Glenharvie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>	
c. LENGTH OF STAY IN 1b <u>13 1/2 hr</u>		d. STREET ADDRESS <u>2 N. Second Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u># 2 - 2nd Ave. Garland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elsie Irene Meldrom</u>		4. DATE OF DEATH Month Day Year <u>April 20 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 25 1897</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days <u>68</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County, state, or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Hunter Ahl</u>		14. MOTHER'S MAIDEN NAME <u>Blanche S. Strong</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Lawrence I. Meldrom</u>		Address <u>2 N. 2nd. Ave.,</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> 443X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Hypertension &amp; Arteriosclerosis</u> (c) <u>Diabetes</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hr</u> <u>10-15 hr</u> <u>5 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/20</u> to <u>4/20</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/20</u> , 19 <u>66</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Chas L. Ball Jr.</u> M.D.		22b. DATE SIGNED <u>4/20/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Chas L. Ball, Jr.</u>		22d. ADDRESS <u>Linthicum 9nd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-23-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard Strong 3rd</u>		25a. RECORD BY REGISTRAR <u>APR 21 1966</u>	
ADDRESS <u>3rd 7th North Ave.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

04733

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04735

## CERTIFICATE OF DEATH

04734

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>5 mos. 24 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>283 Ballou Court</b>	
3. NAME OF DECEASED (Type or print) <b>3-#26237 Elizabeth Michel</b>		4. DATE OF DEATH Month <b>4</b> Day <b>10</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 21, 1894</b>
9. AGE (In years last birthday) yrs. <b>71</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>10</b> Hours <b>19</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Louis Michel</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Weber</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>219-22-7279</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a); (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10/16</b> , 19 <b>63</b> , to <b>4/10</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4/10</b> , 19 <b>66</b> , and that death occurred at <b>3A.</b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>L. Benedict</i>		22b. DATE SIGNED <b>4/11/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>4/13/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Univ. of Maryland</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Wm. Reese II-108 W. Wash. St., Annapolis, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 14 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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04735

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. NAME OF DECEASED (Type or Print) <b>JOSEPH JOHN MILCHENSKI</b>		2. DATE AND HOUR OF DEATH <b>April 19, 1966</b>		3 P. A	
3. PLACE OF DEATH IN: <b>BALTIMORE, MARYLAND</b>  FULL NAME OF ANNE ARUNDEL COUNTY HOSPITAL OR (If not in hospital or institution, give street address or location) INSTITUTION <b>BALTIMORE -25</b>  <b>4217 Third St. Baltimore, Md.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>ANNE ARUNDEL</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore - 25</b>	
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>	
8. DATE OF BIRTH <b>Nov. 21, 1907</b>		9. AGE (In years last birthday) <b>58</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Union Bag Box Factory</b>		11. BIRTHPLACE (State or foreign country) <b>Polland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Thomas Milchenski</b>		14. MOTHER'S MAIDEN NAME <b>Sophie Rosiak</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>195-09-8191</b>		17. INFORMANT <b>Elizabeth Milchenski (same)</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>4201 ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Severe Pulmonary Obstructive Airway Disease</b> <b>Anthrax</b> <b>Myocardial Ischemia</b>		19. CAUSE OF DEATH (A) <b>Severe Pulmonary Obstructive Airway Disease</b> (B) <b>Anthrax</b> (C) <b>Myocardial Ischemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1964-1966</b> <b>--</b>	
20. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>Jan 19 66</b>		21. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		22. HOW DID INJURY OCCUR?	
23. I certify that (I) (this hospital) attended the deceased from <b>January 19 66</b> to <b>April 19 66</b> that (I) (we) last saw the deceased alive on <b>April 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <b>Mario J. Reda</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>April 20, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>Mario Reda</b>		23D. ADDRESS <b>4016 Ritchie Hgwy., Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Apr. 23, 66</b>		24C. NAME of CEMETERY or CREMATORY <b>Glen Haven Memorial Park</b>	
24D. LOCATION <b>Ritchie Hgwy., A.A.Co., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 28 1966</b>			
25B. NAME OF REGISTRAR <b>Charles Judge</b>		25C. FUNERAL DIRECTOR <b>George J. Gonce - 4001 Ritchie Hgwy.</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Md</u> b. COUNTY <u>Anne Arundel</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Gen Hosp.</u>					d. STREET ADDRESS <u>Box 176 Route 6</u>				
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>T.</u> Last <u>MILLER</u>					4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-28-20</u>		9. AGE (In years last birthday) <u>45</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Coast Guard Yard</u>					10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John C. Miller</u>					14. MOTHER'S MAIDEN NAME <u>Marie Hess</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WWII</u>					16. SOCIAL SECURITY NO. <u>213-18-1922</u>		17. INFORMANT <u>Elizabeth Miller, Same as line D.</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive myocardial infarction</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>August 27, 1965</u> to <u>present</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>January 17</u> , 19 <u>66</u> , and that death occurred at <u>9:10 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>C. Earl Hill</u>					22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type) <u>C. Earl Hill, M.D.</u>	
22d. ADDRESS <u>395 Ft. Smallwood Rd. Pasadena Maryland 21122.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-18-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Balto. Natl. Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore, Md</u>		
24. FUNERAL DIRECTOR <u>McCullys, 130 E. Fort Ave, Balto, Md</u>					25a. REC'D BY REGISTRAR <u>APR 18 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>				

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04738

## CERTIFICATE OF DEATH

04738

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>39yrs. 3mos.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>02-1</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>#04724</b>		First <b>Jeanette</b>		Middle <b>Neal</b>		Last <b>Neal</b>		4. DATE OF DEATH Month <b>4</b> Day <b>5</b> Year <b>1966</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>-- 1895 ?</b>		9. AGE (In years last birthday) <b>69 ?</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>5</b> Hours <b>19</b> Min. <b>66</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4221</b> IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>Years</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Obesity</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1/9/</b> , 19 <b>36</b> , to <b>4/5/</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4/5/</b> 19 <b>66</b> , and that death occurred at <b>2:30</b> M. from causes and on the date stated above.									
22a. SIGNATURE <b>L. Benedict, M.D.</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/7/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M.D.</b>				22d. ADDRESS <b>Crownsville, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>4-7-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>U. Baltimore</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE Md.</b>			
24. FUNERAL DIRECTOR <b>William Reese #108 W. Washington St. City</b>				25a. REC'D BY REGISTRAR <b>APR 11 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2524



04739

CERTIFICATE OF DEATH

04739

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>AA</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville Road</b>				d. STREET ADDRESS <b>Glen Burnie</b>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Agnes</b> Last <b>Nevin</b>				4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10 Mar. 1885</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>1</b>		IF UNDER 24 HRS. Hours <b>1</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Ireland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>John Mulcahy</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Doyle</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mr. Thomas Nevin, same as 2</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cocaine of alcohol intoxication</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/12/66</b> 19 to <b>4/13/66</b> 19, that (I) (we) last saw the deceased alive on <b>4/12/66</b> 19, and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Gerard Church</b>				M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Gerard Church, M. D.</b>				22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>16 April 66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial</b>		23d. LOCATION (City, town or county) (State) <b>Glen Burnie, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Kirkley Funeral Home, Glen Burnie, Md.</b>				25. REC'D BY REGISTRAR <b>APR 18 1966</b>			
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION

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Granville Road

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John

James

John

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## CERTIFICATE OF DEATH

04740

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>Davidsonville, Maryland</b>			
3. NAME OF DECEASED (Type or print) First <b>Katherine</b> Middle <b>Lou</b> Last <b>OAKLEY</b>				4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (In years last birthday) <b>59</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during month immediately preceding death) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James B. Kearns</b>				14. MOTHER'S MAIDEN NAME <b>Lou B. Trammell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) -----		16. SOCIAL SECURITY NO. -----		17. INFORMANT <b>Arthur W. Oakley same as #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> 4201 DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>disease</b> 12 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March</b> , 19 <b>64</b> , to <b>April 29</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>April 29</b> , 19 <b>66</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Sylvia M. Lim</b>				22b. DATE SIGNED <b>4/30/66</b>		22c. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) <b>Sylvia Lim, M.D.</b>				22e. ADDRESS <b>Rt. 1 Box 244, Mayo Rd, Edgewater, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 3, 1963</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 2 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ESTIMATE OF RAIN

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June 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04741					04741				
1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort George G Meade</b>			c. LENGTH OF STAY IN 1b <b>5/12</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gambrills</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kimbrough Army Hospital</b>					d. STREET ADDRESS <b>RFD</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>JOSEPH</b> Last <b>O HARA</b>					4. DATE OF DEATH Month <b>APRIL</b> Day <b>13</b> Year <b>1966</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 14 1887</b>		9. AGE (In years last birthday) yrs. <b>79</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>US Army</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Hazleton, Penna</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter O'Hara</b>					14. MOTHER'S MAIDEN NAME <b>Mary (Maiden Name Unknown)</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW1&amp;2</b>			16. SOCIAL SECURITY NO. <b>262-78-7198</b>		17. INFORMANT <b>W.J. O'Hara (Son) Same As Item # 2</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1538</b> IMMEDIATE CAUSE (a) <b>Carcinoma of Colon</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>5/12</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>23 Nov</b> , 19 <b>66</b> , to <b>13 Apr</b> , 19 <b>66</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>13 Apr</b> , 19 <b>66</b> , and that death occurred at <b>12:40 PM</b> , from causes and on the date stated above.									
22a. SIGNATURE <b>L. W. Holder</b>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>13 Apr 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. W. HOLDER, CAPT, MC</b>					22d. ADDRESS <b>HQ Kimbrough Army Hospital FT Meade, Md</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/16/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Our Lady of the Fields Cath Cem, Millers, Md.</b>		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <b>HOPPING FUNERAL HOME - Annapolis, Md.</b>					25a. REC'D BY REGISTRAR <b>APR 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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EXTRACT OF DEATH

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DATE OF DEATH

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## CERTIFICATE OF DEATH

04742

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. LENGTH OF STAY IN 1b <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riva</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>524 Riva Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>OSTER</b> Last <b>OSTER</b>				4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 7, 1892</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min.		11. BIRTHPLACE (County & State, or foreign country) <b>Cincinnati Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Cincinnati Ohio</b>	
13. FATHER'S NAME <b>William Oster</b>				14. MOTHER'S MAIDEN NAME <b>Emma Rodenhouse</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>288-10-4914</b>		17. INFORMANT <b>Mrs. Arna A. Oster - same as #2 above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROSIS, GENERALIZED</b> DUE TO (c) <b>ARTERIOSCLEROSIS, GENERALIZED</b>							INTERVAL BETWEEN ONSET AND DEATH <b>14 HOURS</b> <b>10 YRS.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CHRONIC CHOLECYSTITIS &amp; CHOLELITHIASIS</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <b>physician</b> ) attended the deceased from <b>APRIL 4, 1968</b> , to <b>Apr. 11, 1966</b> , that (I) ( <b>xx</b> ) last saw the deceased alive on <b>Apr. 11, 1966</b> , and that death occurred at <b>10:10 PM</b> , from causes on the date stated above.							
22a. SIGNATURE <b>Edward S. Beck</b>				22b. DATE SIGNED <b>4-12-66</b>		22c. PHYSICIAN'S NAME (Type) <b>Edward S. Beck, M.D.</b>	
22d. ADDRESS <b>71 Franklin St., Annapolis, Md.</b>				22e. REC'D BY REGISTRAR <b>APR 14 1966</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>?</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stephens Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Fort Thomas, Campbell, Ky.</b>	
24. FUNERAL DIRECTOR <b>Beverly E. Hopping</b>				25. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04743 CERTIFICATE OF DEATH 04743									
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>					d. STREET ADDRESS <b>86 Pleasant St.,</b>			02-1	
3. NAME OF DECEASED (Type or print) First <b>Randolph</b> Middle <b>NMN</b> Last <b>PARKER</b>					4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>19 66</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 14, 1913</b>		9. AGE (In years last birthday) <b>52</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General Housework</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (County & State, or foreign country) <b>A.A.Co Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Ernest Parker</b>					14. MOTHER'S MAIDEN NAME <b>Kate Owens</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW LI</b>			16. SOCIAL SECURITY NO. <b>214-05-2365</b>		17. INFORMANT <b>Mrs Kate Alspp</b> Address <b>1962 West St Annapolis Md</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> <b>Cerebral hemorrhage.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Hypertension</b> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) <del>(the doctor)</del> attended the deceased from <b>4/12</b> , 19 <b>66</b> , to <b>Apr. 13</b> , 19 <b>66</b> that (I) <del>(we)</del> saw the deceased alive on <b>Apr. 13</b> , 19 <b>66</b> , and that death occurred at _____ M, from causes and on the date stated above.									
22a. SIGNATURE <b>Gerard Church</b>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7:30 AM 4/13/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>Gerard Church</b>			22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>4-16-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Annapolis A.A. Md</b>		
24. FUNERAL DIRECTOR <b>C.E. Hicks, 111</b>			ADDRESS <b>Annapolis, Maryland</b>						
25a. REC'D BY REGISTRAR <b>APR 15 1966</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						

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208: 21890

## CERTIFICATE OF DEATH

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04744

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN b. <b>Minutes</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>AA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severn</b>		d. STREET ADDRESS <b>New Cut Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>William Byron Phelps, Sr.</b>		4. DATE OF DEATH <b>April 15, 1966</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>25 June 1908</b>		9. AGE (In years last birthday) <b>57</b>		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>National Plastics</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Willie E. Phelps</b>		14. MOTHER'S MAIDEN NAME <b>Daisy Fairall</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW 11</b>		16. SOCIAL SECURITY NO. <b>717-07-6852</b>			
17. INFORMANT <b>Mrs. Isabelle C. Phelps, same as 2</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Cardio-Vascular Disease</b> 260x Conditions, if any, which gave rise to immediate cause (b) <b>Hypertension</b> (c) <b>Diabetes</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>6-8 M -</b> <b>10-15 M -</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/15</b> , 19 <b>66</b> , to <b>4/15</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4/15</b> , 19 <b>66</b> , and that death occurred at <b>2</b> P.M. from the causes and on the date stated above.																	
22a. SIGNATURE <b>Charles L. Ball Sr.</b>		22b. DATE SIGNED <b>4/16/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Charles Ball, M. D.</b>		22d. ADDRESS <b>Linthicum, Md.</b>		22e. REC'D BY REGISTRAR <b>APR 18 1966</b>		22f. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>18 April 66</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Nichols Bethel Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Odenton, AA Co., Md.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Kirkley Funeral Home, Glen Burnie, Md.</b>		24. ADDRESS <b>Kirkley Funeral Home, Glen Burnie, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		25c. DATE <b>APR 18 1966</b>		25d. SIGNATURE <b>J. Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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*Journal of Interpersonal Violence*

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Section 1001

## Discussion

David M. Vaisey

2004 • J. Neurosci., September 22, 10(39):10000–10007 • 10007

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

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59. *continued*

Charles F. Johnson, N. Y. C.

[illegible]

Figure 2. Left:  $\chi^2$  of fit. Right:  $\chi^2$  of fit.

Ed. 579.81

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04745

## CERTIFICATE OF DEATH

04745

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL COUNTY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FT. GEO. G. MEADE</b>		c. LENGTH OF STAY IN lb <b>5 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>KIMBROUGH ARMY HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SUSAN First MARIE Middle Last PITOCHELLI</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>12</b> Year <b>19 66</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7 APRIL 1966</b>
9. AGE (In years lost birthday) <b>0 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>5</b> Hours <b></b> Min. <b></b>	
11. BIRTHPLACE (County & State, or foreign country) <b>ANNE ARUNDEL, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>SABATINO PITOCHELLI</b>		14. MOTHER'S MAIDEN NAME <b>ELAINE TERREAU</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>FATHER, SAME AS ITEM # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>7511 IMMEDIATE CAUSE (a) Memingomyelocoele</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>(a)</del> (this hospital) attended the deceased from <b>7 Apr</b> , 19 <b>66</b> , to <b>12 Apr</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12 Apr</b> , 19 <b>66</b> , and that death occurred at <b>5:10 A.M.</b> , from causes and on the date stated above			
22a. SIGNATURE <i>Burton A. Johnson</i> 22c. PHYSICIAN'S NAME (Type) <b>BURTON A JOHNSON, CAPT, MC</b>		22b. DATE SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>12 APRIL 1966</b>	
22d. ADDRESS <b>KIMBROUGH ARMY HOSPITAL, FT MEADE, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>April 19, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>IMMACULATE CONCEPTION Cem., Lawrence, Mass..</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 18 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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04746

## CERTIFICATE OF DEATH

04746

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>Box-44A</b>	
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Bell</b> Last <b>POSTON</b>		4. DATE OF DEATH Month <b>April</b> Day <b>22</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 17, 1886</b>
9. AGE (In years lost birthday) yrs. <b>79</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William R. Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Delia Haywood</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Betty Tucker</b>		Address <b>Bx 44A Davidsonville. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Coronary arteriosclerosis (Right)</b> DUE TO (c) <b>_____</b>			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchopneumonia (severe), Diabetes mellitus, Cerebral atrophy</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the Registrar) attended the deceased from <b>16 Apr</b> , 19 <b>66</b> to <b>Apr. 22</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>April 22</b> , 19 <b>66</b> , and that death occurred at <b>9:15 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Charles W. Kinzer</b>		22b. DATE SIGNED <b>9:15 AM</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles W. Kinzer, M.D.</b>		22d. ADDRESS <b>South RivMedCent., Edgewater, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-26-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince George, Md.</b>	
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b>		25a. BY REGISTRAR <b>APR 27 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04740

CERTIFICATE OF DEATH

01710

Name of Deceased		Date of Death		Place of Death	
John Doe		April 15, 1950		New York City	
Sex		Age		Cause of Death	
Male		45		Heart Disease	
Occupation		Residence		Burial Place	
Teacher		123 Main St.		Cemetery	
Signature of Physician		Signature of Registrar		Signature of Witnesses	
[Signature]		[Signature]		[Signatures]	
Date of Certificate		Place of Issuance		Official Seal	
April 16, 1950		New York City		[Seal]	



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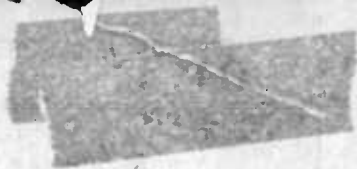
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04747											
04747											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>					c. LENGTH OF STAY IN 1b <u>2 yrs.</u>						
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>					d. STREET ADDRESS <u>200 S. Hammonds Ferry Road</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u># 200 S. Hammonds Ferry Road</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>B.</u> Last <u>Pueschel</u>					4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1966</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 21, 1898</u>		9. AGE (In years last birthday) <u>68</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		IF UNDER 1 YEAR Months <u>02</u> Days <u>01</u>			
13. FATHER'S NAME <u>August Schmidt</u>					14. MOTHER'S MAIDEN NAME <u>Ernestine Gliewe</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Ada Dornbush (niece)</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>As Ht. fails c. actual fibrill.</u> (c) <u>Chronic dilatation of liver</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 yrs.</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic dilatation of liver</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>None</u>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>4:24</u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Baltimore, Maryland</u>		
21. I certify that (I) (the hospital) attended the deceased from <u>Jan 1963</u> to <u>4/24/66</u> that (I) (we) last saw the deceased alive on <u>4/24/66</u> 19 <u>66</u> , and that death occurred at <u>10 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>CHRISTIAN S. WASS, M.D.</u>					22b. DATE SIGNED <u>4/25/66</u>						
22c. PHYSICIAN'S NAME (Type) <u>BALTIMORE NAT'L. PIKE &amp; ST. JOHN'S LANE</u> <u>ELICOTT CITY, MD.</u>					22d. ADDRESS <u>Singleton Funeral Home</u> <u>Glen Burnie, Md</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>April 27, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Immanuel's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>		
24. FUNERAL DIRECTOR <u>R.V. Singleton</u>					25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>					25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	
DATE <u>APR 26 1966</u>											

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04748

## CERTIFICATE OF DEATH

04748

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>02-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>532 Sixth St.,</b>	
3. NAME OF DECEASED (Type or print) <b>SARAH Sadie ELIZABETH RAWLINGS</b>		4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 9, 1876</b>
9. AGE (In years lost birthday) yrs. <b>89</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Annapolis, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>ALONZO HUBBARD</b>	
14. MOTHER'S MAIDEN NAME <b>ELIZABETH FREEMAN</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>MRS Lillian Root #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Ac. Myocardial Infarction</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>17 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>diabetes Mellitus. Infirmities of age</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/13/66</b> to <b>Apr. 30, 19 66</b> that (I) (we) last saw the deceased alive on <b>Apr. 30</b> 19 <b>66</b> , and that death occurred at <b>10:40 AM</b> M, from causes and on the date stated above.		22a. SIGNATURE <b>Maurice Klawans</b> M.D.	
22c. PHYSICIAN'S NAME (Type) <b>Maurice Klawans, M.D.</b>		22d. ADDRESS <b>31 Southgate Ave., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-3-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR Bluff</b>		23d. LOCATION (City or Town) (County) (State) <b>Annapolis A.A. Md.</b>	
24. FUNERAL DIRECTOR <b>John M. Lytle &amp; Sons Annapolis, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 4 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

01714

John Doe

John Doe

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Old Herald Harbor Rd</u>					d. STREET ADDRESS <u>Box 364 Old Herald Harbor Rd.</u>				
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Pauline</u> Last <u>Redding</u>			4. DATE OF DEATH Month <u>Apr.</u> Day <u>20</u> Year <u>1966</u>						
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 17, 1962</u>		9. AGE (In years last birthday) <u>3</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>never worked</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Omaha, Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael N. Redding</u>					14. MOTHER'S MAIDEN NAME <u>Mary M. Damico</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Michael N. Redding - Same as #2 above</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia - Burns 3rd° blue</u> <u>9160</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>House Fire</u>						
20c. TIME OF INJURY Month, Day, Year Hour <u>8 a.m.</u> <u>4-20</u> 196 <u>6</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Anne Arundel Md.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE <u>[Signature]</u>			22. DATE SIGNED <u>4-20-66</u>						
EXAMINER'S NAME (Type) <u>F. L. [Signature]</u>			Address (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>4/22/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince George Co. Md.</u>		
24. FUNERAL DIRECTOR <u>Bridley E. Hopping</u> HOPPING FUNERAL HOME - Annapolis, Md.			25a. REC'D BY REGISTRAR <u>APR 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

00100

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D. C.

April 2, 1966

Dear Sir:

Enclosed for you are

three copies of a letterhead memorandum dated and captioned as above.

The letterhead memorandum is being furnished to you for your information.

Very truly yours,

Director

Enclosure

Very truly yours,

Director

Enclosure

Very truly yours,

Director

Enclosure

Very truly yours,

Director

Enclosure

Very truly yours,

Director

APR 2 1966

100-100000-1000

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

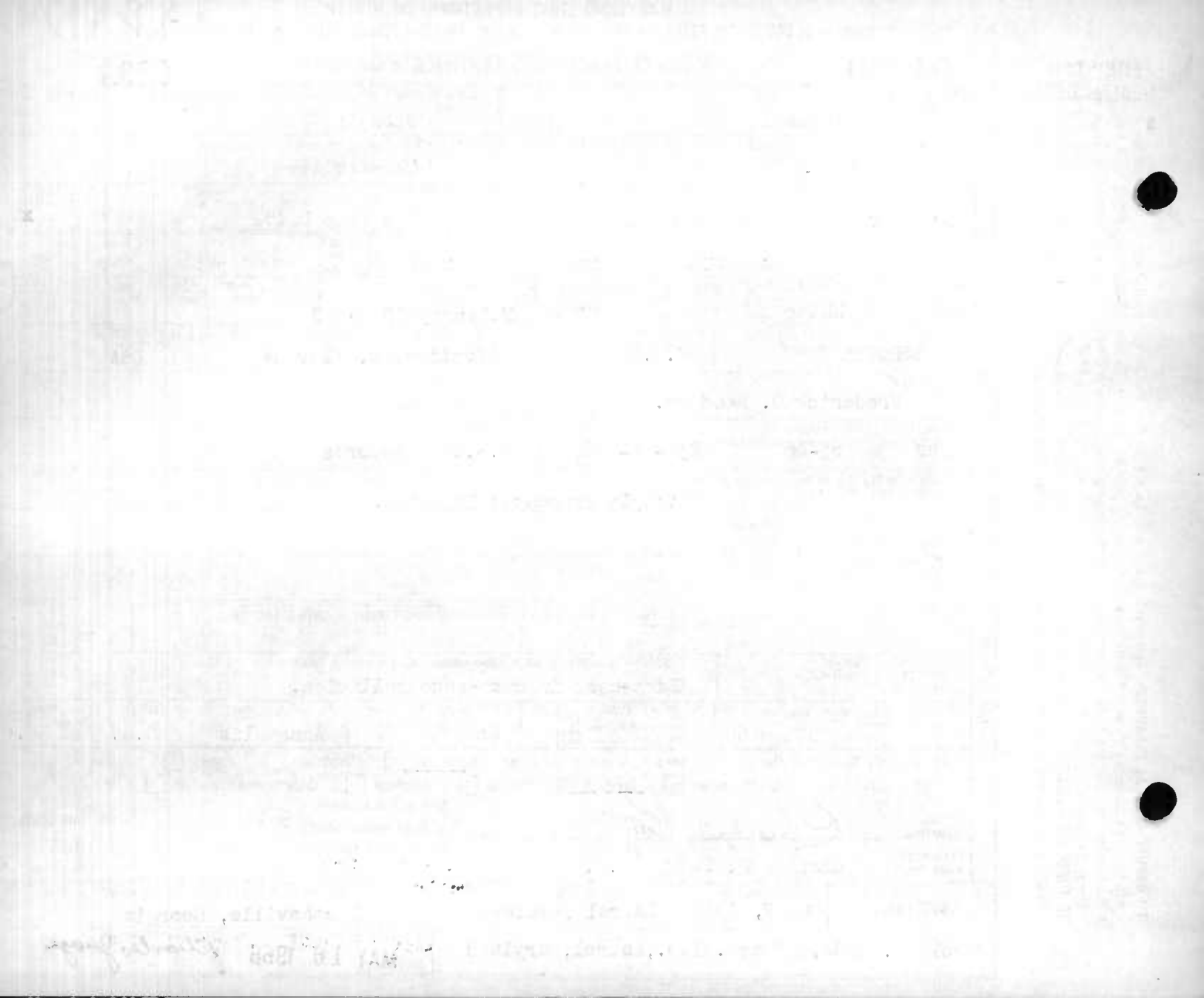
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04750

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06398

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Georgia</b> b. COUNTY <b>Thomasville</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thomasville</b> 49-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>			d. STREET ADDRESS <b>405 Palm Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>OTTO</b> Last <b>REED</b>			4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>19 66</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 15, 1945</b>		9. AGE (In years lost birthday) yrs. <b>21</b>
10a. USUAL OCCUPATION (Give kind of work done during most of last year, or if retired) <b>SOLDIER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. ARMY</b>		11. BIRTHPLACE (State or foreign country) <b>Monticello, Florida</b>	
13. FATHER'S NAME <b>Frederick O. Reed Sr.</b>			14. MOTHER'S MAIDEN NAME <b>unknown</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>yes 65-66</b>		16. SOCIAL SECURITY NO. <b>259-66-7827</b>		17. INFORMANT <b>U.S. ARMY records</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Traumatic Injuries.</b> 8164 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in auto-auto collision.</b>			
20c. TIME OF INJURY Hour <b>4:30</b> p.m. Month, Day, Year <b>4/30 19 66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>	
		20f. (City or town) <b>Annapolis</b>		(County) <b>A.A.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles S. Petty</b>		EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>		22. DATE SIGNED <b>5/1/66</b>	
23a. BURIAL, CREMATION, or other disposition <b>BURIAL</b>		23b. DATE THEREOF <b>May 7, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Cemetery</b>	
				23d. LOCATION (City or Town) (County) (State) <b>Thomasville, Georgia</b>	
24. FUNERAL DIRECTOR <b>Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland</b>			25a. REC'D BY REGISTRAR <b>MAY 10 1966</b>		
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04751											
04751											
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GAMBRILLS</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAMBRILLS</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RIEDEL ROAD</u>						d. STREET ADDRESS <u>RIEDEL ROAD</u>					
3. NAME OF DECEASED (Type or print) <u>JOSEPH</u> First <u>RIEDEL</u> Middle <u>RIEDEL</u> Last						4. DATE OF DEATH <u>4</u> Month <u>24</u> Day <u>1966</u> Year					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-9-1881</u>		9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH RIEDEL</u>						14. MOTHER'S MAIDEN NAME <u>THERESA STURM</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs. RAY CHAPMAN #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>										INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u> <u>10 YRS.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>July 4</u> , 19 <u>62</u> to <u>24 APR</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2 APR</u> , 19 <u>66</u> , and that death occurred at <u>7P</u> M from the causes and on the date stated above.											
22a. SIGNATURE <u>Edward S. Beck</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-26-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>ANNAPOLIS, MD.</u>						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-27-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		23d. LOCATION (City, town or county) <u>Suitland</u> (State) <u>MD.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR &amp; SONS</u> ADDRESS <u>Annapolis, Md.</u>						25a. REC'D BY REGISTRAR <u>APR 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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UNITED STATES OF AMERICA

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MARGARETS</u>		c. LENGTH OF STAY IN 1b <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BAY MANOR NURSING HOME</u>		d. STREET ADDRESS <u>8 FRANKLIN ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>G.</u> Last <u>RUHLMAN</u>		4. DATE OF DEATH Month <u>4</u> Day <u>12</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-1882</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BANKING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TELLER</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>ANNAPOLIS MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Ruhman</u>		14. MOTHER'S MAIDEN NAME <u>Matilda E. Goodwin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>CHRISTINE S. RUHMAN #2</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>  </u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>  </u> Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that (I) (this hospital) attended the deceased from <u>1/20</u> 19 <u>66</u> to <u>4/13</u> 19 <u>66</u> , that (I) <u>last</u> saw the deceased alive on <u>4/11</u> 19 <u>66</u> , and that death occurred at <u>7:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard I. Hochman, M.D.</u>		22b. DATE SIGNED <u>4/14/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, M.D.</u>		22d. ADDRESS <u>59 Franklin St. Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-15-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>	23d. LOCATION (City, town or county) (State) <u>ANNAPOLIS MD.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Ly...</u>		25a. REC'D BY REGISTRAR <u>APR 15 1966</u>	
ADDRESS <u>Annapolis, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

12528

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04753

CERTIFICATE OF DEATH

04752

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville, Md.</u>		c. LENGTH OF STAY IN 1b <u>16-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Knollwood Nursing Home</u>		d. STREET ADDRESS <u>3019 Savoy Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Glover</u> Last <u>Ryan</u>		4. DATE OF DEATH <u>April 7</u> 19 <u>66</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 5, 1879</u>
9. AGE (In years lost birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>never worked</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Glover</u>		14. MOTHER'S MAIDEN NAME <u>Marion Thursby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Marion Maguire-daughter same as #2 above</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO (b) <u>coronary occlusion</u> DUE TO (c) <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>65</u> , to <u>April 5</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>April 5</u> , 19 <u>66</u> and that death occurred at <u>4:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>R M Smith</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>RAY M. SMITH M.D.</u>		22d. ADDRESS <u>Severna Park Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/11/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Yonkers N.Y.</u>	
24. FUNERAL DIRECTOR <u>Beverly E. Hopping</u>		25a. REC'D BY REGISTRAR <u>APR 11 1966</u>	
HOPPING FUNERAL HOME - Annapolis, Md.		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



83000

UNITED STATES DEPARTMENT OF JUSTICE

83010

10

10

10. The following information was obtained from the records of the Department of Justice, Bureau of Prisons, and the Federal Bureau of Investigation, and is being furnished to you for your information. It is not to be used for any other purpose.

10. The following information was obtained from the records of the Department of Justice, Bureau of Prisons, and the Federal Bureau of Investigation, and is being furnished to you for your information. It is not to be used for any other purpose.



04754

CERTIFICATE OF DEATH

04753

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>4 hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ANNE ARUNDEL GEN HOSPITAL</b>		d. STREET ADDRESS <b>225 Carroll Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>MARIE ROSALIA SAGER</b>		4. DATE OF DEATH Month <b>4</b> Day <b>8</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 28, 1892</b>
9. AGE (In years lost birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Johnstown, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John W. Gerber</b>		14. MOTHER'S MAIDEN NAME <b>Kunigunda Stummer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>----</b>	
17. INFORMANT <b>John Gerber, 225 Carroll Rd., Riviera Beach</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MASSIVE CEREBRAL HEMORRHAGE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>UNKNOWN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 HOURS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1962</b> , 19____, to <b>1966</b> , 19____, that (I) (we) last saw the deceased alive on <b>APRIL 8</b> , 19 <b>66</b> , and that death occurred at <b>4:40 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Arthur Lankford Jr MD</b>		22b. DATE SIGNED <b>4-8-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR LANKFORD JR MD</b>		22d. ADDRESS <b>MOUNTAIN RD PASADENA, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 12, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Ritchie Hgwy., A.A.Co., Md.</b>	
24. FUNERAL DIRECTOR <b>George J. Gonce - 4001 Ritchie Hgwy., Baltimore</b>		25a. MEDICAL REGISTRAR <b>APR 11 1966</b>	
25b. CORONER'S SIGNATURE <b>James Judge</b>		25c. JUDGE'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

007523

RECORDS OF DEATH

1963

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1140	1141	1142	1143	1144	1145	1146	1147	1148	1149	1150	1151	1152	1153	1154	1155	1156	1157	1158	1159	1160	1161	1162	1163	1164	1165	1166	1167	1168	1169	1170	1171	1172	1173	1174	1175	1176	1177	1178	1179	1180	1181	1182	1183	1184	1185	1186	1187	1188	1189	1190	1191	1192	1193	1194	1195	1196	1197	1198	1199	1200	1201	1202	1203	1204	1205	1206	1207	1208	1209	1210	1211	1212	1213	1214	1215	1216	1217	1218	1219	1220	1221	12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FOR STATE HEALTH DEPT.  
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, see the Medical Examiner, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.  
VS. A15ME  
SM 7/59

1  
04755  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
04754

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Hospital				d. STREET ADDRESS Box 20B, Valley Road			
3. NAME OF DECEASED (Type or print) First Middle Last DOROTHY ANNA SAILORS				4. DATE OF DEATH Month Day Year April 20 19 66			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 10, 1919	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ins. Underwriter				10b. KIND OF BUSINESS OR INDUSTRY Employers Group Assur.		11. BIRTHPLACE (State or foreign country) Savannah, Georgia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Willis Lee Scoggins				14. MOTHER'S MAIDEN NAME Pearl Franklin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 215-18-7168		17. INFORMANT Address Madison H. Sailors Valley Rd., Hanover, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Head. 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Home			
20c. TIME OF INJURY Hour a.m. XXXX 4/19 19 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hanover A.A. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Charles S. Petty, M.D. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/21/66							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 23, 1966		22c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum		22d. LOCATION (City, town, or country) (State) Woodlawn Balto. Co. Maryland	
23. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks, Inc. 1217 St. Paul Street				24a. REC'D BY REGISTRAR APR 25 1966 24b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04756					04755				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <b>Anne Arundel</b> MARYLAND					a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Annapolis</b>				02-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>					d. STREET ADDRESS <b>Rt. 4, Box 115</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)			First <b>Anthony</b> Middle <b>V.</b> Last <b>SAKIE</b>		4. DATE OF DEATH		Month <b>April</b> Day <b>8</b> Year <b>1966</b>		19 <b>66</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>April 2, 1894</b>		9. AGE (In years last birthday) <b>72 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Anthony</b>					14. MOTHER'S MAIDEN NAME <b>Ona</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Joseph Wiegman Mountain View</b>		Address <b>4538-29</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>451 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Recurrent Aortic Aneurysm</b> DUE TO (c) <b>= blood loss at surgery.</b>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> , to <b>19</b> , that (I) (we) last saw the deceased alive on <b>April 8, 1966</b> , and that death occurred on <b>April 8, 1966</b> at <b>6:30 PM</b> , from causes and on the date stated above.									
22a. SIGNATURE <b>Stephen B. Hiltabidle</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>April 5 '66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Stephen B. Hiltabidle M. D.</b>					22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/12/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baeso National</b>		23d. LOCATION (City or Town) (County) (State) <b>Baeso, Md.</b>			
24. FUNERAL DIRECTOR <b>Witke F. P. 4101 Edmondson Ave</b>					ADDRESS		25a. REC'D BY REGISTRAR DATE <b>APR 11 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

0453



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
04757 CERTIFICATE OF DEATH 04756													
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>143 Greenland Beach 5 months</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 26. 02-1</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>none</i>						d. STREET ADDRESS <i>143 Greenland Beach Road</i>							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <i>Charles Clarence</i> Middle <i>Sawyer</i> Last <i>Sawyer</i>						4. DATE OF DEATH Month <i>April</i> Day <i>7</i> Year <i>1966</i>							
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 2, 1888</i>		9. AGE (in years last birthday) <i>77</i> yrs.		IF UNDER 1 YEAR Months <i>7</i> Days <i>7</i> Hours <i>19</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>police man</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>police</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Avon, Ohio</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>David Sawyer</i>						14. MOTHER'S MAIDEN NAME <i>Elsie Gleason</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>yes WW I</i>				16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Mrs. Mary Day</i>			Address <i>same</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the prostate gland</i> <i>1992</i> DUE TO (b) <i>and urinary bladder</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <i>none</i>												INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>none</i>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>3</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>November 30, 1965</i> , to <i>Apr. 7</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Apr. 5</i> , 19 <i>66</i> , and that death occurred at <i>8 P.M.</i> from the causes and on the date stated above.													
22a. SIGNATURE <i>R. M. McLaughlin</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>4/7/66</i>					
22c. PHYSICIAN'S NAME (Type) <i>R. M. McLaughlin</i>						22d. ADDRESS <i>3708 Mountain Rd. Pasadena, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>April 11, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Brookdale Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Elyria, Ohio</i>				
24. FUNERAL DIRECTOR <i>George J. Gonce - 4001 Ritchie Hwy., Baltimore Md.</i>						25a. REC'D BY REGISTRAR <i>APR 11 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

04756

UNITED STATES OF AMERICA

1938



George J. Gagne - 1901-1988  
Born 11, 1901, Brooklyn, New York  
Died 11, 1988, Elmhurst, New York

04758

## CERTIFICATE OF DEATH

04757

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Baltimore City</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY in 1b <b>43 yrs</b> <b>11 mos. 27 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>30-4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) <b>3-#01624 Thomas Scales</b>			4. DATE OF DEATH Month <b>4</b> Day <b>11</b> Year <b>19 66</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/6/1895 (approx.)</b>		9. AGE (In years last birthday) <b>71 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Hand</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country)	
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Hospital Records</b> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>443X</b> IMMEDIATE CAUSE (a) <b>Hypertensive Cardio-Vascular Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. ----- 19	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>	20f. (City or town) (County) (State) <b>-----</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>4/14</b> , 19 <b>66</b> , to <b>4/11</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4/11</b> , 19 <b>66</b> , and that death occurred <b>at 8:30 PM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>L. Benedict, M. D.</b>			22b. DATE SIGNED <b>4/14/66</b>		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>4/15/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Univ. of Maryland</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>		
24. FUNERAL DIRECTOR <b>Wm. Reese</b>			25a. REC'D BY REGISTRAR <b>APR 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04731

RECORD OF DEATH

1919

First Name

Last Name

Place of Birth

Age

Sex

Marital Status

IV

Signature

Date

Witness

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04759

04758

FOR STATE  
HEALTH DEPT

1. PLACE OF DEATH a. COUNTY <u>AA CO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA CO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Milkenville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA - NORTH ARUNDEL</u>		d. STREET ADDRESS <u>Scuppernon Road</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph W. Schwartz</u>		4. DATE OF DEATH Month <u>4</u> Day <u>24</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-10-16</u>
9. AGE (In years lost birthday) yrs. <u>49</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>24</u> Hours <u>19</u> Min. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Schwartz</u>		14. MOTHER'S MAIDEN NAME <u>Florence Simmons</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-05-9082</u>	
17. INFORMANT <u>Mrs. Florence V. Schwartz</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic disease</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		22. DATE SIGNED <u>4-24-66</u>	
EXAMINER'S NAME (Type) <u>F. L. [Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 27, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, AA Co., MD.</u>
24. FUNERAL DIRECTOR <u>R. V. Singleton</u>		25a. REC'D BY REGISTRAR <u>APR 26 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11-20



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04760 CERTIFICATE OF DEATH 04759											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Davidsonville</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>					d. STREET ADDRESS <u>--</u>						
3. NAME OF DECEASED (Type or print)			First <u>Veta</u> Middle <u>Luella</u> Last <u>Sears</u>		4. DATE OF DEATH		Month <u>April</u> Day <u>11</u> Year <u>1966</u>				
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 13, 1922</u>		9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Durango, Col.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Robert Nelson</u>					14. MOTHER'S MAIDEN NAME <u>Ella Walker</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>523-18-8246</u>		17. INFORMANT <u>Robert C. Sears</u>			Address <u>same as #2 above</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gen. carcinomatosis</u> 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of breast</u> DUE TO DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Aug.  </u> , 19 <u>46</u> , to <u>Apr. 11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Apr. 11</u> , 19 <u>66</u> , and that death occurred at <u>1 p.m.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>S. Borssuck</u> M.O.					ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>4/12/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>S. Borssuck, M.D.</u>					22d. ADDRESS <u>Amos Garrett Blvd., Annapolis, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr. 13, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Davidsonville Metho</u>			23d. LOCATION (City, town or county) (State) <u>Davidsonville Md.</u>				
24. FUNERAL DIRECTOR <u>HOPPING FUNERAL HOME</u>					ADDRESS <u>Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

10150

STATE OF TEXAS

10150

10150

APR 14 1962

04761

## CERTIFICATE OF DEATH

04760

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>Annopolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>191 Clay St.,</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Cora Winfred SIMMS</b>		4. DATE OF DEATH Month Day Year <b>April 21 1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 7, 1897</b>
9. AGE (In years last birthday) yrs. <b>68</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Augustus Baden</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Hurall</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Brenda Tongue</b>		Address <b>544 Duke St. Garden</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis hypertensive</b> (c) <b>cardio vascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>11-10-66</b>		20f. (City or town) (County) (State) <b>11-20-66</b>	
21. I certify that (I) ( <del>we</del> ) attended the deceased from <b>4-18-66</b> , 19 <b>66</b> , to <b>4-20-66</b> , 19 <b>66</b> , that (I) ( <del>we</del> ) saw the deceased alive on <b>4-18-66</b> , 19 <b>66</b> , and that death occurred at <b>9:10 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>A. T. Allen</b>		22b. DATE SIGNED <b>APR 22 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. T. Allen, M.D.</b>		22d. ADDRESS <b>62 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/25/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys</b>		23d. LOCATION (City or Town) (County) (State) <b>Annapolis, Md.</b>	
24. FUNERAL DIRECTOR <b>William Reese, Jr - Annapolis, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04762 CERTIFICATE OF DEATH 04761									
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>28 W. Washington Street</b>					d. STREET ADDRESS <b>28 W. Washington Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>ALEXANDER</b> Last <b>SIMPSON</b>					4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>19 66</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 22-1875</b>		9. AGE (In years last birthday) <b>90</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chef - retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Annapolis, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes - S.A.W. &amp; W.W.1</b>			16. SOCIAL SECURITY NO. <b>220-09-5498</b>		17. INFORMANT Address <b>Annie S. Henry-28 W. Washington-Anna. Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>a day</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1-7-66</b> , 19 <b>66</b> , to <b>4-19-66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4-16-66</b> , 19 <b>66</b> , and that death occurred at <b>4:00</b> A.M., from the causes and on the date stated above.									
22a. SIGNATURE <b>A.T. Allen</b>					22b. DATE SIGNED <b>4-20-66</b>				
22c. PHYSICIAN'S NAME (Type) <b>A.T. Allen</b>					22d. ADDRESS <b>Cathedral St. Annapolis, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 22-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>			23d. LOCATION (City, town or county) (State) <b>Annapolis, Md.</b>		
24. FUNERAL DIRECTOR <b>C.E. Hicks III</b>					ADDRESS <b>Annapolis, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 25 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

04763

04762

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN 1b <b>18 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		d. STREET ADDRESS <b>600 S. Crain Highway</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>600 S. Crain Highway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Meta</b> Middle <b>Dora</b> Last <b>Snyder</b>		4. DATE OF DEATH Month <b>April</b> Day <b>8</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 21, 1892</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <b>73</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Clement Lehnert</b>		14. MOTHER'S MAIDEN NAME <b>Maria Lindeman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>----</b>	
17. INFORMANT <b>Gordon Snyder, 819 Lynvue Rd., Linthicum, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease 5 yrs</b> DUE TO <b>—</b> (c) <b>—</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obesity</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>—</b> p. m. <b>—</b> 19 <b>66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) (County) (State) <b>—</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>4/2</b> 19 <b>66</b> , to <b>4/2</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4/2</b> 19 <b>66</b> , and that death occurred at <b>10A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>R.W. Prichard</b>		22b. DATE SIGNED <b>APR 11 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>R.W. PRICHARD</b>		22d. ADDRESS <b>Glen Burnie, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 12, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Gonce,</b>		25. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
ADDRESS <b>4001 Ritchie Highway Baltimore, Md. 21225</b>		25a. REC'D BY REGISTRAR <b>APR 11 1966</b>	

CERTIFICATE OF TITLE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04764											
04763											
1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b> c. LENGTH OF STAY IN b <b>3 Mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RAY MANOR NURSING HOME</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>2015 St. PAUL St.</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>ELIZABETH ZOLLER STARR</b>						4. DATE OF DEATH Month Day Year <b>APRIL 4, 1966</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 6, 1876</b>		9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>WILLIAM H. ZOLLER</b>						14. MOTHER'S MAIDEN NAME <b>LIZZIE V. McLANE</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MRS. JEAN S. O'DONOVAN 2015 St. PAUL St.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>coronary occlusion</b> DUE TO (c) <b>arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>few minutes</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 27, 1965</b> to <b>April 4, 1966</b> , that (I) (we) last saw the deceased alive on <b>April 4, 1966</b> , and that death occurred at <b>4</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>R M Smith</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>April 4, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>RAY M. Smith M.D.</b>						22d. ADDRESS <b>Severna Park Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 6, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN</b>				23d. LOCATION (City, town or county) (State) <b>WOODLAWN, MD.</b>			
24 FUNERAL DIRECTOR'S SIGNATURE <b>H. H. Meador</b> ADDRESS <b>805 N. Calvert St.</b>						25a. REC'D BY REGISTRAR <b>APR 6 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please provide carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04765											
04764											
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				d. STREET ADDRESS <u>112 CHARLES ST</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ANNAPOLIS NURSING HOME</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>PAUL</u> <u>E. STINCHCOMB</u>			4. DATE OF DEATH Month Day Year <u>APR.</u> <u>26</u> <u>1966</u>								
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APR 24 1891</u>		9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.A. Co. GUY.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTABLE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ANNAPOLIS MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>ANDREW J. STINCHCOMB</u>						14. MOTHER'S MAIDEN NAME <u>Mary Florence Bryan</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>ELNORA W. STINCHCOMB</u>		Address <u>#2</u>			
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arterio-sclerotic CVP</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>IX hyp left</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Fell in Street</u>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>3-18-66</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Street</u>		20f. (City or town) <u>Ann Arundel</u>		(County) <u>MD</u>		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 24</u> , 19 <u>66</u> to <u>4-26-66</u> , that (I) (we) last saw the deceased alive on <u>4-24-66</u> , 19 <u>66</u> , and that death occurred at <u>112 Charles St</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Frank M. Shipley</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>F.M. SHIPLEY</u>						22d. ADDRESS <u>Ann Arundel</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-28-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S CEM.</u>		23d. LOCATION (City, town or county) <u>ANNAPOLIS MD.</u>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR SON ANNAPOLIS MD</u>						ADDRESS <u>ANNAPOLIS MD</u>		25a. REC'D BY REGISTRAR <u>MAY 2 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



RECEIVED

1974

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C. 20535

MEMORANDUM FOR THE ATTORNEY GENERAL

DATE: 10/10/74

TO: THE ATTORNEY GENERAL

FROM: [illegible]

SUBJECT: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																								
04766					CERTIFICATE OF DEATH					04765														
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <i>Maryland</i> b. COUNTY <i>Queen Anne</i> ✓																			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural Annapolis</i>					c. LENGTH OF STAY IN 1b <i>17-2</i>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Centreville</i>														
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
3. NAME OF DECEASED (Type or print) <i>Anna</i> First <i>Gertrude</i> Middle <i>Taylor</i> Last					4. DATE OF DEATH <i>April</i> Month <i>17</i> Day <i>19</i> Year <i>66</i>																			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 26, 1873</i>		9. AGE (In years last birthday) <i>92</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) <i>Denton, Maryland</i>					12. CITIZEN OF WHAT COUNTRY <i>USA</i>									
13. FATHER'S NAME <i>Peter Foster Hignutt</i>					14. MOTHER'S MAIDEN NAME <i>Martha Jane Neal</i>																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT <i>Anna Taylor, Centreville, Maryland</i>					Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> <i>4201</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerosis</i> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i>few hours</i>														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <i>April 17, 1966</i> , that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <i>134 PM</i> , from the causes and on the date stated above.																								
22a. SIGNATURE <i>Ray M. Smith</i>										22b. DATE SIGNED <i>4-17-66</i>														
22c. PHYSICIAN'S NAME (Type) <i>RAY M. SMITH M.D.</i>										22d. ADDRESS <i>Severna Park Md.</i>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>					23b. DATE THEREOF <i>April 20</i>					23c. NAME OF CEMETERY OR CREMATORY <i>Chesterfield</i>					23d. LOCATION (City, town, or county) (State) <i>Centreville, Maryland</i>									
24. FUNERAL DIRECTOR <i>Edgar L. Kane</i>										ADDRESS <i>Church Hill, Maryland</i>					25a. REC'D BY REGISTRAR <i>APR 25 1966</i>					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

04785

STATE OF TEXAS

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04767

## CERTIFICATE OF DEATH

04766

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		c. LENGTH OF STAY IN 1b <b>40 yrs</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b> <b>47-3</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Children's Center Hospital</b>		d. STREET ADDRESS <b>1111 - 5th St., S. E.</b>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Earl</b> Last <b>Taylor</b>		4. DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-7-00</b>
9. AGE (In years last birthday) yrs. <b>65</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Institutionalized</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert T. Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Padgett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Children's Center Hospital, Laurel, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the prostate with metastasis</b> DUE TO (b) <b>Thyroid goiter</b> DUE TO (c) <b>Mental retardation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN DEATH AND DEATH <b>30 23 48</b> <b>to death</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>February 18, 19 66</b> to <b>April 27, 19 66</b> , that (I) (we) last saw the deceased alive on <b>April 27, 19 66</b> , and that death occurred at <b>1:00 p.m.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>George T. Economos</b>		22b. DATE SIGNED <b>April 28, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>GEORGE T. ECONOMOS, M. D.</b>		22d. ADDRESS <b>Children's Center, Laurel, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5-2-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Children's Center</b>	23d. LOCATION (City or Town) (County) (State) <b>Laurel Md.</b>
24. FUNERAL DIRECTOR <b>DeWitt Sanadran Laurel Md</b>		25a. REC'D BY REGISTRAR <b>MAY 5 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 2682, 2683, 2684, 2685, 2686, 26

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04768 CERTIFICATE OF DEATH 04767									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Millersville</u> c. LENGTH OF STAY IN 1b <u>66-4 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Knowlwood Manor Nursing Home</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arden on the Severn - Crownsville</u> d. STREET ADDRESS <u>25 Waterview Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>M.</u> Last <u>Teufel</u>			4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1966</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/17/1912</u>		9. AGE (In years last birthday) <u>53</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary U.S. Government</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Teufel</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth Shuey</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Archie Davis</u> Address <u>33 Waterview Dr. Arden on the Severn, Crownsville</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis -</u> <u>172X</u> DUE TO (b) <u>Adeno Carcinoma of Endometrium</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 yr. 1 1/2 yrs.</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>7-9, 1964</u> to <u>4-26, 1966</u> , that (I) (we) last saw the deceased alive on <u>7-14, 1966</u> , and that death occurred at <u>3:30</u> M. from the causes and on the date stated above.									
22a. SIGNATURE <u>Alexander L. Russell</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-26-66</u>				
22c. PHYSICIAN'S NAME (Type) <u>Alexander L. Russell</u>			22d. ADDRESS <u>7709 Meadow Lane Chevy Chase, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Apr. 29, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Our Lady of the Fields</u>		23d. LOCATION (City, town or county) (State) <u>Millersville Md.</u>		
24. FUNERAL DIRECTOR <u>Bessie L. Hopping</u> ADDRESS <u>Hopping Funeral Home Annapolis, Md.</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				
DATE <u>APR 29 1966</u>									

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FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)  
5M 1/65

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04769

04768

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>98 SHIPWRIGHT ST.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>98 SHIPWRIGHT ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH MEADE THOMAS</u>				4. DATE OF DEATH Month Day Year <u>APRIL 16 1966</u>			
5. SEX <u>FEM</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-10-1904</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INDEX SUPPL. OF CONGRESS U.S. GOV'T</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WASH. D.C.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>WILLIAM H. MEADE</u>				14. MOTHER'S MAIDEN NAME <u>EVELINA HAYES</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>MR. ROBERT THOMAS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500</u> <u>Myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				22. DATE SIGNED <u>4-16-66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>APR 20 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CREM. PRI. GEO. CO. MD.</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR, Soas</u>				25a. REC'D BY REGISTRAR <u>APR 21 1966</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04770

CERTIFICATE OF DEATH

04769

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FT GEORGE G MEADE</b>				c. LENGTH OF STAY IN 1b -			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>KIMBROUGH ARMY HOSPITAL</b>				d. STREET ADDRESS <b>7011A BAKER STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>WILBURN</b> Last <b>TODD</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>22</b> Year <b>19 66</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAUC</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC 6, 1930</b>	
9. AGE (In years last birthday) <b>35</b> yrs.		IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b>		IF UNDER 24 HRS. Hours <b>-</b> Min. <b>-</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SOLDIER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>US ARMY</b>		11. BIRTHPLACE (County & State, or foreign country) <b>HORRY, S. CAROLINA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>BENTLEY W. TODD</b>				14. MOTHER'S MAIDEN NAME <b>ALMA H. HARDEE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES 6 Sep 48 - 22 Apr 66</b>				16. SOCIAL SECURITY NO. <b>247-46-0663</b>		17. INFORMANT <b>OFFICIAL MILITARY RECORDS (SP NOGY)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONTACT GUNSHOT WOUND</b> DUE TO (b) <b>DESTRUCTIVE BRAIN DAMAGE</b> DUE TO (c) <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>SELF INFLICTED GUNSHOT WOUND</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>2:45</b> p.m. <b>APR 22</b> 19 <b>66</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOME</b>	
20f. (City or town) (County) (State) <b>FT G G MEADE, ANNE ARUNDEL MD</b>							
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>APRIL 22</b> , 19 <b>66</b> , to <b>APRIL 22</b> , 19 <b>66</b> , that (I) (we) saw the deceased alive on <b>19</b> , and that death occurred at <b>4:30 PM</b> , from causes and on the date stated above							
22a. SIGNATURE <i>Fred M. Nomura</i>				22b. DATE SIGNED <b>APRIL 22, 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>FRED M. NOMURA, CAPT, MC</b>	
22d. ADDRESS <b>KIMBROUGH ARMY HOSPITAL, FT MEADE MD</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 29, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLLY HILL CEM</b>		23d. LOCATION (City or Town) (County) (State) <b>LORIS SOUTH CAROLINA</b>	
24. FUNERAL DIRECTOR <b>HAROLD S. WADE, 550 W 45th BLVD, LAUREL, MD</b>				25a. REC'D BY REGISTRAR <b>MAY 2 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04771

CERTIFICATE OF DEATH

04770

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>109 DUKE OF GLOUCESTER</b>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>P.</b> Last <b>TURNER</b>		4. DATE OF DEATH Month <b>April</b> Day <b>8</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 12 1882</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>P.C. PRIEST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Priest</b>	9. AGE (In years (last birthday) yrs. <b>84</b> )
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>PATRICK TURNER</b>		14. MOTHER'S MAIDEN NAME <b>KATHERINE ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>ST. MARV'S RECTORY #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>493x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebrum - still undetermined</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>Feb 66</b> , 19 <b>66</b> , to <b>April 8</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>April 8</b> , 19 <b>66</b> , and that death occurred at <b>11:10 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Gerard Churel</b>		22b. DATE SIGNED <b>4/11/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>GERARD CHUREL</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-11-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>REDEMPTORIST CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>ANNAPOLIS A.A.C. MD.</b>	
24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR, 8009 ANNAPOLIS MD.</b>		25a. REC'D BY REGISTRAR <b>APR 13 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04773 CERTIFICATE OF DEATH 04772									
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>AA</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Severn</b>			c. LENGTH OF STAY IN 1b <b>70 Yrs.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Severn</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>New Cut Road</b>					d. STREET ADDRESS <b>New Cut Road</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Edward</b>		First <b>Lee</b>		Middle <b>Upton</b>		Last		4. DATE OF DEATH Month <b>April 2,</b> Day <b>19</b> Year <b>66</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 31, 1877</b>		9. AGE (In years last birthday) <b>88</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Ret.</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Anne Arundel Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John W. Upton</b>					14. MOTHER'S MAIDEN NAME <b>Eliza Jane Day</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Annie M. Upton, same as 2</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> 6/17X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Gastric Intestinal Tract Infection</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>66</b> , to <b>4-2</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>April 2, 1966</b> , and that death occurred at <b>1:45 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Wayne B. Tate</b>					22b. DATE SIGNED <b>Apr. 4, 1966</b>				
22c. PHYSICIAN'S NAME (Type) <b>Wayne B. Tate, M.D.</b>					22d. ADDRESS <b>108 Central Ave. NW, Glen Burnie, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>April 5, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Glen Burnie, Md.</b>		
24. FUNERAL DIRECTOR <b>Kirkley Funeral Home, Glen Burnie, Md.</b>					25a. REC'D BY REGISTRAR <b>APR 6 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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108 Central Ave. N., Glen Burnie, Md.

108 Central Ave. N., Glen Burnie, Md.

April 5, 1966 Glen Green Memorial Park, Glen Burnie, Md.

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108 Central Ave. N., Glen Burnie, Md.

108 Central Ave. N., Glen Burnie, Md.

1. PLACE OF DEATH a. COUNTY <u>A.A.Co.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.Co.</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>117 Monticello Ave</u>						e. STREET ADDRESS <u>116 SpA View Ave.</u>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mahcolm W Waring</u>						4. DATE OF DEATH Month Day Year <u>4 3 1966</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-3-1904</u>		9. AGE (In years last birthday) yrs. <u>62</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ADM. Assistant State Of. MD.</u>						11. BIRTHPLACE (County & State, or foreign country) <u>St. Margarets, MD.</u>							
13. FATHER'S NAME <u>J. EVERETT Waring</u>						14. MOTHER'S MAIDEN NAME <u>Masonetta Stinecomb</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>-</u>							
17. INFORMANT Address <u>Augusta B. Waring #2</u>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4301 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>instantly.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Note: <u>I did not attend this man; death caused by Dr. Elmer Kibben.</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>fall</u>									
20c. TIME OF INJURY Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from....., 19...., to....., 19...., that (I) (we) last saw the deceased alive on.....19...., and that death occurred at <u>about 4PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>[Signature]</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/6/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>[Name]</u>						22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>4-6-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ASBURY</u>				23d. LOCATION (City, town or county) (State) <u>ARNOLD A.A.Co MD</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Layton &amp; Sons Annapolis, Md.</u>						25a. REC'D BY REGISTRAR <u>APR 6 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7-62

John H. Johnson  
4-1-10  
Agency

115 Monticello Ave  
Annapolis  
Maryland

AA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

04775

04774

<b>1. PLACE OF DEATH</b> a. COUNTY <i>A. D.</i> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harwood</i> c. LENGTH OF STAY IN 1b <i>Harwood</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) e. STATE <i>MD</i> b. COUNTY <i>A. D.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harwood</i> d. STREET ADDRESS <i>02-1</i> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <i>Mary Virginia Watkins</i> First Middle Last <b>4. DATE OF DEATH</b> Month Day Year <i>4-25 1966</i>		<b>5. SEX</b> <i>Female</i> <b>6. COLOR OR RACE</b> <i>Col</i> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <i>WIDOWED</i> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <i>6.5.1876</i> <b>9. AGE</b> (In years last birthday) <i>89</i> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Housewife</i> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Maryland</i> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <i>U.S.A.</i> <b>12. CITIZEN OF WHAT COUNTRY</b> <i>U.S.A.</i>		<b>13. FATHER'S NAME</b> <i>John H. Randall</i> <b>14. MOTHER'S MAIDEN NAME</b> <i>Charlotte Randall</i>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <i>no</i> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <i>John H. Watkins Harwood MD</i> <b>17. INFORMANT</b> Address <i>John H. Watkins Harwood MD</i>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Hypertensive Cardiovascular Disease</i> (e), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <i>19</i>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <i>9-5-66</i> <b>20f. (City or town) (County) (State)</b> <i>Harwood A. D. MD</i>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <i>4-19-66</i> <b>to</b> <i>4-24-66</i> <b>19</b> <i>66</i> <b>that (I) (we) last saw the deceased alive on</b> <i>4-19-66</i> <b>19</b> <i>66</i> <b>and that death occurred at</b> <i>11:50</i> <b>A.M.</b> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <i>T. Allen</i> <b>22c. PHYSICIAN'S NAME</b> (Type) <i>T. ALLEN</i>		<b>22b. DATE SIGNED</b> <i>6-2-66</i> <b>22d. ADDRESS</b> <i>Cathedral St</i>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <i>Burial 4-28-66</i> <b>23b. DATE THEREOF</b> <i>4-28-66</i> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>Cathedral St</i> <b>23d. LOCATION</b> (City, town or county) (State) <i>Lothian MD</i>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>William Reese</i> <b>25a. REC'D BY REGISTRAR</b> <i>Charles Judge</i> <b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i> <b>DATE</b> <i>APR 26 1966</i>	

04774

CONTINUATION OF DATA

04774

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to be organized into sections, possibly describing a survey or study.]*





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 6. *Myrica* *maritima* L.  
 7. *Myrica* *maritima* L.  
 8. *Myrica* *maritima* L.  
 9. *Myrica* *maritima* L.  
 10. *Myrica* *maritima* L.

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 00/00/4  
 1,000 2,000  
 H2A

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04777

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04775

1. PLACE OF DEATH a. COUNTY <u>AA. Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ARMCO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie.</u>		c. LENGTH OF STAY IN 1b —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>00A - North - ARNOLD -</u>				d. STREET ADDRESS <u>821 - Oak - Road.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rebecca</u> Middle <u>C.</u> Last <u>White</u>				4. DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/24/16</u>		9. AGE (In years lost birthday) yrs. <u>49</u>	10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Snow Camp, N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas C. Carter</u>				14. MOTHER'S MAIDEN NAME <u>Lucy R. (unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>239-03-2696</u>		17. INFORMANT <u>Mrs. Harold L. White (Husband)</u>		18. Address <u>Same As #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral disease</u> <u>4344</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>[Signature]</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED	
EXAMINER'S NAME (Type) <u>E. L. H. H. H.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>4/21/66</u>	
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 24, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pine Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Burlington, N. Carolina</u>	
24. FUNERAL DIRECTOR <u>R. V. Singleton</u>		ADDRESS <u>Singleton Funeral Home</u>		25a. REC'D BY REGISTRAR <u>APR 26 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

05730

Thomas C. (Lester)  
2-18-88 (Lester)  
100-10-1000 to 1000-10-1000

APR 28 1988  
John B. Brown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04778									
04777									
Item 9 Film 4575 4/7/66 mb									
1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDAL</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FT GEO G MEADE</b> c. LENGTH OF STAY IN 1b <b>44 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>KIMBROUGH ARMY HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE, MD.</b> d. STREET ADDRESS <b>1 DAVID LEE RD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>LUCINDA</b>			First Middle Last <b>WHITT</b>		4. DATE OF DEATH Month Day Year <b>APRIL 2 1966</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAU</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2 Sept 1889</b>		9. AGE (In years last birthday) <b>76 77 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (County & State, or foreign country) <b>HOCKING OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GEORGE WASHINGTON HUTCHINSON</b>					14. MOTHER'S MAIDEN NAME <b>ANGELINE TATEMAN</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>UNK</b>		16. SOCIAL SECURITY NO. <b>UNK</b>		17. INFORMANT <b>MARY E. CHAMP (DAU) 1 DAVID LEE RD.</b>		Address <b>CATONSVILLE, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DIFFUSE CARCINOMATOSIS</b> (c) <b>CARCINOMA OF BREAST</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CONTRIBUTING TO DEATH</b>								INTERVAL BETWEEN ONSET AND DEATH <b>5 MONTHS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>18 FEB</b> , 19 <b>66</b> , to <b>2 APR</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12 FEB</b> , 19 <b>66</b> , and that death occurred at <b>920PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Jeffress Boozer</b>								22b. DATE SIGNED <b>2 APR 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JEFFRESS BOOZER/CAPT/MC</b>					22d. ADDRESS <b>KIMBROUGH ARMY HOSPITAL</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>4/4/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Columbus, Ohio</b>			23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR <b>Wm. Lickman</b>				ADDRESS <b>Wm. Lickman</b>		25a. REC'D BY REGISTRAR <b>APR 4 66</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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M

04779  
04778  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>AA</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Ordinance Rd.</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <b>Md.</b> b. COUNTY <b>AA</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BrooklynPk</b> d. STREET ADDRESS <b>Ordinance Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>Henry</b> Last <b>Wiedenhoef</b>		4. DATE OF DEATH Month <b>4</b> Day <b>6</b> Year <b>1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 28, 1902</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Concrete Block Layer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Ludwig Wiedenhoef</b>		14. MOTHER'S MAIDEN NAME <b>Anna</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Stoll</b>		Address <b>Ordinance Rd. # 26</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Insufficiency - Hypertension</b> (c) <b>Arteriosclerotic Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>4 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 31, 1966</b> to <b>April 6, 1966</b> , that (I) (we) last saw the deceased alive on <b>April 6, 1966</b> , and that death occurred at <b>9A M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Loung Glass</b>		22b. DATE SIGNED <b>4/6/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>LC</b>		22d. ADDRESS <b>320 PATAPSCO AVE</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-8-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Beth 25 Md.</b>	
24. FUNERAL DIRECTOR <b>McCully Funeral Home</b>		ADDRESS <b>237 Patapsco Ave. 25</b>	
25a. REC'D BY REGISTRAR <b>APR 11 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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# FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04780

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04779

1. PLACE OF DEATH a. COUNTY <u>A.A.C.O.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.C.O.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick New Burnie</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DCHA - North Avenue 1 - Hospital</u>				d. STREET ADDRESS <u>RD 9 - Box 202 -</u>			
3. NAME OF DECEASED (Type or print) First <u>Bessie E.</u> Middle <u>WILKES</u> Last <u>WILKES</u>				4. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-8-1893</u>	
				9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>19</u> Hours <u>66</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-22-6240</u>		17. INFORMANT <u>John Wilkes</u> Address <u>1029 W. Lexington</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis Generalized</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>4-5-66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/14/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington S. Phillips</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>Arington S. Phillips</u>				25a. REC'D BY REGISTRAR <u>APR 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

10-17-77

MEMORANDUM FOR THE DIRECTOR

10-17-77

10-17-77

## CERTIFICATE OF DEATH

04780

1. PLACE OF DEATH a. COUNTY <b>CROWNSVILLE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNE R ARUNDEL</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CROWNSVILLE STATE HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HOLLYWOOD</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>VIOLET</b> Middle <b>WILKINSON</b> Last 4. DATE OF DEATH Month <b>APRIL</b> Day <b>29</b> Year <b>1966</b>		5. SEX <b>F</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>8-22-1897</b> 9. AGE (In years last birthday) <b>67</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND, USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BENJAMIN TIPPETT</b>		14. MOTHER'S MAIDEN NAME <b>HANNAH XXXXXXXX NORRIS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-12-2456 B</b>	
17. INFORMANT <b>WILMER E. WILKINSON</b>		Address <b>HOLLYWOOD, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEART FAILURE</b> 4221 DUE TO <b>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DEPRESSIVE REACTION</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/14/66</b> to <b>4/29/66</b> ; that (I) (we) last saw the deceased live on <b>4/29/66</b> , and that death occurred at <b>6:30 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. L. M. Hagg</b>		22b. DATE SIGNED <b>4/29/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Violet M. Hagg</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> ADDRESS <b>Crownsville State Hospital, Crownsville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-3-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. James</b>		23d. LOCATION (City or Town) (County) (State) <b>Hollywood St. Mary's</b>	
24. FUNERAL W. CLARK MATTINGLEY LEONARDTOWN, Md.		25a. REC'D BY REGISTRAR <b>MAY 4 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of and in any event, within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film G376 5/2/66 mh

04782

## CERTIFICATE OF DEATH

04781

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>1 mo. 18 Das</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>1018 Stoddard Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>#31467 Cora Williams</b>				4. DATE OF DEATH Month <b>4</b> Day <b>25</b> Year <b>19 66</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-5-76</b>		9. AGE (In years lost birthday) yrs. <b>89</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) <b>Calvert County</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Foster</b>				14. MOTHER'S MAIDEN NAME <b>Mary</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> <b>455X</b> DUE TO Decubitus Ulcers & Gangrene of Lower Left (b) <b>Extremity &amp; Senility</b> DUE TO (c) <b>Extremity &amp; Senility</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month <b>4</b> Day <b>19</b> Year <b>1966</b> Hour <b>11</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Crownsville, Maryland</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/7/66</b> to <b>4/25/66</b> , that (I) (we) last saw the deceased alive on <b>4/25/66</b> , and that death occurred on <b>4/25/66</b> at <b>11:15</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Lionel M. Henry</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/25/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lionel M. Henry, M.D.</b>				22d. ADDRESS <b>Crownsville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>4/29/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore</b>	
24. FUNERAL DIRECTOR <b>Manuel P. Hayes</b>				ADDRESS <b>638 N. Gilmor St</b>		25a. REC'D BY REGISTRAR DATE <b>APR 27 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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COPIES TO BE MADE

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DATE: 1-1-79

TIME: 10:00

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04783

CERTIFICATE OF DEATH

04782

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL Hospt</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BAY RIDGE</u>	
f. STREET ADDRESS <u>284 W. LAKE DR.</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CORNELIA I. WITHERSPOON</u>		4. DATE OF DEATH <u>4</u> <u>15</u> <u>1966</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-29-1876</u> <u>89</u> yrs.	
9. AGE (In years) <u>89</u>		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>TENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DARIUS WATERHOUSE</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA MORGAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>H.V. WITHERSPOON</u> #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute leukemia, acute type not chronic</u> <u>2043</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last. DUE TO (c) }		INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept.</u> , 19 <u>65</u> , to <u>April</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>April 14</u> , 19 <u>66</u> , and that death occurred at <u>6:30</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>4/15/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>FOREST DR ANNAPOLIS, MD.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>4-15-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d. LOCATION (City, town or county) (State) <u>ANNAPOLIS MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>ANNAPOLIS, MD.</u>		25a. REC'D BY REGISTRAR <u>APR 18 1966</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04784											
Item 2 Film 6375 4/11/66 mh											
04783											
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital						d. STREET ADDRESS 1709 N. Calvert Street					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) #30111 Anna T. Wright			First Middle Last			4. DATE OF DEATH 4 4 19 66			Month Day Year		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/21/80		9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY -----				11. BIRTHPLACE (County & State, or foreign country) Maryland, Baltimore		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME <del>UNKNOWN</del> Nicholas Tegges						14. MOTHER'S MAIDEN NAME <del>UNKNOWN</del> Margaret Miller					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 219-01-0070		17. INFORMANT Miss Lula M. Measch (Hospital Records) 3808 Fleetwood					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 715X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) Decubitus Ulcers OUE TO (c) Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Arteriosclerotic Cardia Vascular Disease Mellitus Diabetes											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) ----- 20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Crownsville, Maryland 20f. (City or town) (County) (State) Crownsville, Maryland											
21. I certify that (I) (this hospital) attended the deceased from 8/9/1965, to 4/4/1966, that (I) (we) last saw the deceased alive on 4/4/1966, and that death occurred at 9:30 M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Lionel McHenry Mapp</i>						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 4/4/66		
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D.						22d. ADDRESS Crownsville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4/7/66			23c. NAME OF CEMETERY OR CREMATORY St Matthews			23d. LOCATION (City, town or county) (State) Baltimore Maryland		
24. FUNERAL DIRECTOR HENRY SANDER & SONS INC. BALTO. MD.						25a. REC'D BY REGISTRAR APR 6 1966			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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04785

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04784

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LINTHIUM				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LINTHIUM			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) #34 COLONIAL DRIVE				e. STREET ADDRESS #34 COLONIAL DRIVE			
6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last IOA YEAGER				4. DATE OF DEATH Month Day Year APRIL 11, 1966			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 15, 1887	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK (ret.)				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME SAMUEL FINK				14. MOTHER'S MAIDEN NAME AGNES (unknown)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 194 10 0921		17. INFORMANT MRS. DOROTHY WILKIE (daughter) SAME AS #	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X CORONARY THROMBOSIS DUE TO (b) ATHERO-sclerosis, Hypertension DUE TO (c) diabetes mellitus				INTERVAL BETWEEN ONSET AND DEATH Two days 5 years 20 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gout, gall stones, bleeding diverticulitis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Jan., 1960, to 4-10-66, that (I) (we) last saw the deceased alive on 4-10-66, and that death occurred at 3 AM, from the causes and on the date stated above.							
22a. SIGNATURE Bahram Sina				22b. DATE SIGNED APRIL 11, 1966			
22c. PHYSICIAN'S NAME (Type) BAHRAM SINA				22d. ADDRESS #11 E. CHASE ST., BALTIMORE, MD.			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APRIL 14, 1966		23c. NAME OF CEMETERY OR CREMATORY FREEMSBURG CEMETERY		23d. LOCATION (City, town or county) (State) BETHLEHEM, PENNSYLVANIA	
24. FUNERAL DIRECTOR R.V. SINGLETON				25a. REC'D BY REGISTRAR APR 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	
SINGLETON FUNERAL HOME GLEN BURNIE, MARYLAND							

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CONFIDENTIAL - SECURITY INFORMATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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04786

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04785

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rt 2 Box 73</u>		d. STREET ADDRESS <u>Rt 2 Box 73</u>	
3. NAME OF DECEASED (Type or print) <u>William Rudolph Young</u>		4. DATE OF DEATH Month <u>4</u> Day <u>11</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7 1908</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Eng</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Eng</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Young</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>21509428</u>	
17. INFORMANT <u>Chester Handy Severna Park, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>C.C.U.D.</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> , 19 <u>55</u> , to <u>66</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>4-5-66</u> 19 <u>  </u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert R. Hober</u> M.D.		22b. DATE SIGNED <u>4-11-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert R. Hober</u>		22d. ADDRESS <u>P.O. Box 73 Severna Park</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-14-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem</u>		23d. LOCATION (City, town or county) (State) <u>Glen Burnie, Md</u>	
24. FUNERAL DIRECTOR <u>Severna Park Fun. Home, Severna Park, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 15 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>		DATE	

1878



Received of the Treasurer of the  
Board of Directors of the  
City of New York  
the sum of \$100.00  
for the year 1878